Beyond Victimization

Understanding and Addressing Victimization and Discrimination as Barriers to Societal Participation of Individuals with Severe Mental Illness

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ISBN: 978-94-6506-486-4

Provided by thesis specialist Ridderprint, ridderprint.nl
Printing: Ridderprint
Layout and design: Dagmar Versmoren, persoonlijkproefschrift.nl

The research in this dissertation was funded by the Netherlands Organization for Scientific Research (NWO, grant number 432-12-808).

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Understanding and Addressing Victimization and Discrimination as Barriers to Societal Participation of Individuals with Severe Mental Illness

Proefschrift

ter verkrijging van de graad van doctor aan Tilburg University
op gezag van de rector magnificus, prof. dr. W.B.H.J. van de Donk,
in het openbaar te verdedigen ten overstaan van een door het college voor
promoties aangewezen commissie in de Aula van de Universiteit op
vrijdag 17 januari 2025 om 13.30 uur

door

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geboren te Venray

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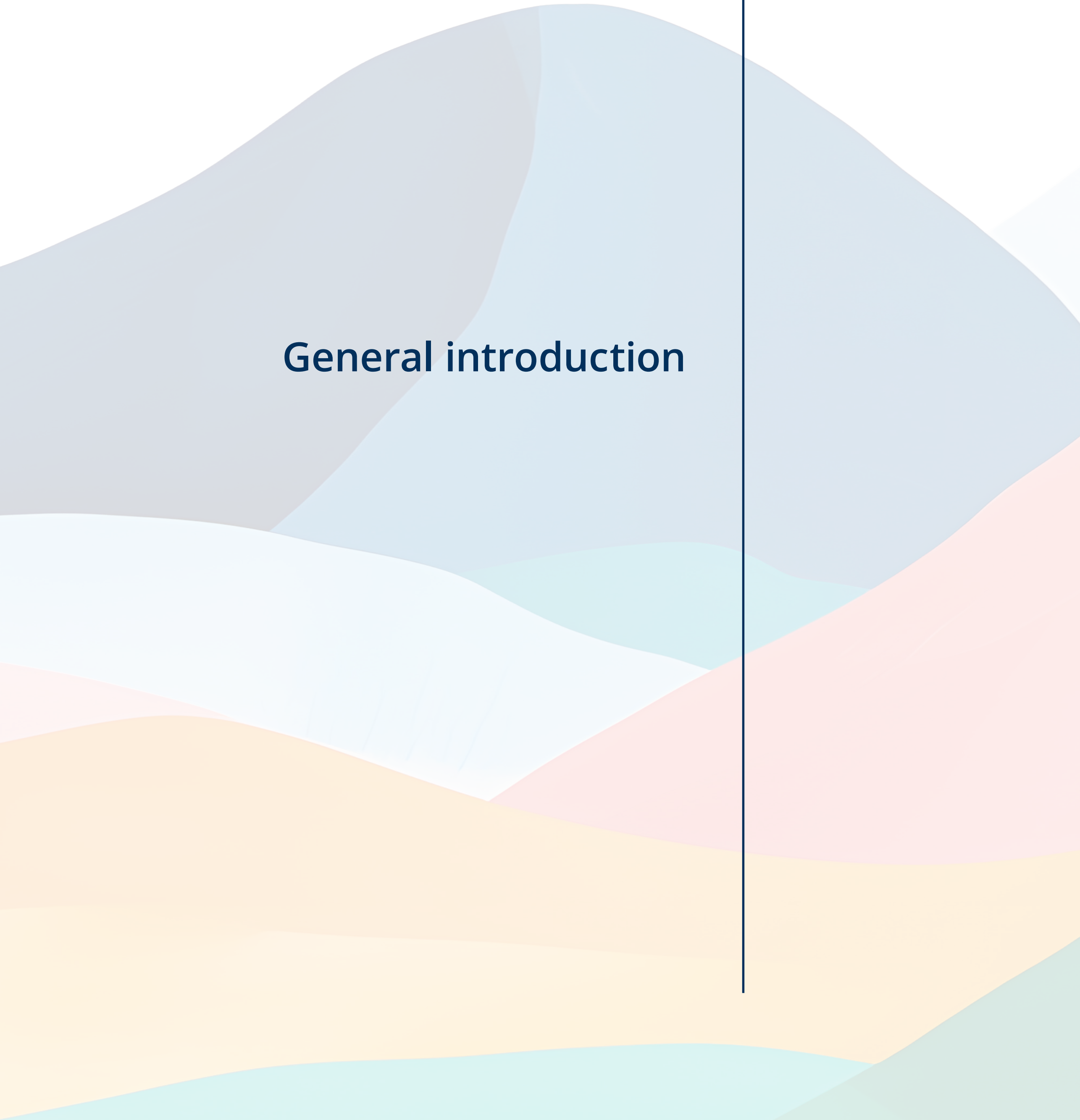
General introduction



Introduction

> *Marina, a woman in her late 50s diagnosed with schizophrenia in adolescence, receives outpatient counseling from FACT. Despite living independently, she faced challenges caring for her husband with alcohol addiction, who passed away a decade ago. Her adult son visits a few times a year. Battling psychoses involving a threatening "neighbor," Marina's social environment sees it as a sign of worsening mental health. During better periods, Marina yearns for social contact and explored a day activity center with her therapist. After two visits, she discontinued attendance as she found it boring. In a revealing conversation, however, Marina discloses inviting someone from the day activity center home, where he overstayed his welcome and made unwelcome advances. Traumatized by the encounter, she fears encountering him again and opted to avoid the activity center.*
>
> *Peter is a 32-year-old, socially reserved man who grew up on a farm with his four older sisters. He lives alone and works on an assembly line at a car factory. Peter has been in ambulatory mental health care for several years for a schizoaffective disorder and has made progress after a period of instability marked by psychotic episodes. Peter desires a relationship but faces challenges as his social circle mainly comprises family members and male colleagues. At a recent family gathering, he met his sister's new neighbor, a recently divorced woman. Engaging in a conversation, Peter became a supportive figure for her emotional distress. However, he felt frustrated when his sister intervened, redirecting the neighbor to the kitchen. This was not the first time Peter perceived his family obstructing potential connections with women, exacerbating his struggle to expand his social involvement beyond family and male colleagues at work.*

During this study, we came across many such stories. Both short narratives illustrate the complex struggles clients endure in their desire for social inclusion amid mental health challenges.

Individuals with severe mental illness (SMI) are increasingly transitioning from institutionalized settings to living within society, yet this shift, known as de-institutionalization, does not guarantee their full integration into community life [1]. Despite the stronger focus on the rehabilitation and societal recovery of individuals with SMI in recent years within mental health care contexts [2,3], their level of societal participation remains much lower compared to the rest of the population [4-9]. This discrepancy is concerning, as individuals with SMI, like anyone else, aim to regain valuable social roles and a sense of belonging [10]. Moreover, societal participation is recognized as an important source for recovery [11,12].

Hence, we need further exploration to understand what hinders in the societal participation process for individuals with SMI. Several significant developments contribute to this discussion. Firstly, there is growing evidence that individuals with SMI face various under-recognized risks while engaging in society, leading to discouragement and avoidance. This includes experiencing stigma and discrimination due to their psychiatric diagnosis [13-16]. More recently, the evidence is growing that many experience serious crime victimization, including the experience of violence (sexual assault, physical assault), property crimes (theft, burglary), digital crimes (identity fraud or hacking), and (emotional) abuse and social exploitation [17-23]. Disturbingly, many of these victimization experiences occur within the individual's own social network [24]. Understandably, the impact of these experiences is enormous, including not only an individual's self-esteem and quality of life, but also increasing the chance of substance use [13,25-28]. Additionally, the "why try" effect may emerge, hindering the ability to connect with others and pursue meaningful work and daily activities, caused by a feeling of discouragement [29].

Secondly, there is increasing attention, brought up by people with lived experience, that risks are part of life, and often serve as necessary learning opportunities on an individual's road to recovery. Rather than emphasizing risk prevention, advocates of the "dignity of risk" concept promote risk management and encourage participation, asserting that clients have the right to take reasonable risks [30]. These developments pose a dilemma for both clients and professional caregivers. Further professional guidelines are needed for this, as mental health professionals find themselves continuously balancing between facilitating risk-taking and ensuring safety during rehabilitation and recovery-oriented mental health care [26,31].

This study started in 2013 as part of the program Violence against Psychiatric Patients, developed by the Dutch Organization of Scientific Research (NWO) and Stichting tot Steun VCVGZ. At that time, only a few international studies examined the prevalence and risk factors of victimization [32-34], and no Dutch studies were conducted. Therefore, the overarching aim of this program was to examine the prevalence, risk factors, and consequences of violence against individuals with SMI in the Netherlands and to develop interventions preventing victimization and mitigating its adverse effects. Even in international literature, little to no studies existed that included the whole spectrum, ranging from subtle disadvantage and social deprivation to victimization of crimes. Furthermore, the personal consequences, such as feelings of insecurity or withdrawal from social life were hardly addressed in existing studies [26]. The aim of this dissertation is therefore to explore the role of victimization in the participation of individuals with SMI and develop and evaluate an intervention for mental health professionals that aims to enhance societal participation and take calculated risks while doing so.

Below, we delineate the extent to which individuals with SMI participate in society. Following this, we provide a description of the various barriers they encounter in this process, according to the current state of the literature. Finally, we outline how these barriers are addressed within community mental health care thus far, as a fundament for the following chapters.

Severe mental illness

Mental illnesses are common. In the Netherlands, according to a national population study, 26% of all citizens have had a mental illness in the past 12 months and nearly half of the Dutch adult population have had a mental illness at some point in their lives [35]. Individuals for whom the mental illness persists and seriously influences their functioning (or the other way around) represent approximately 1.5% of the population [36]. According to Delespaul et al. this group is characterized by: 1) a psychiatric disorder requiring treatment, 2) severe impairment in social and/or societal functioning, 3) a psychiatric disorder, 4) which is present for at least several years, and 5) necessitating coordinated mental health care [37]. In this thesis we will use the term SMI when referring to this group, although international literature often employs a somewhat wider definition of SMI, excluding the last two criteria of Delespaul et al. [38].

Recovery is integral to the definition. According to Delespaul et al., individuals who achieve five years of remission (symptomatic and functional), should no longer be defined as having a SMI. Schizophrenia and other psychotic disorders are the most prevalent diagnoses in this group, followed by bipolar disorder, personality disorder, developmental disorder, and substance abuse [37,39]. While individuals with SMI are a heterogeneous group, they share common challenges across multiple life domains. Only a small percentage has paid employment, they often rely on benefits, and they often experience difficulties in relationships and daily activities [40].

Societal participation of individuals with SMI

Just like anyone else, individuals with SMI yearn for social connection and a sense of belonging [41]. Despite extensive efforts through rehabilitation and recovery interventions, many individuals with SMI still face challenges in fully participating in interpersonal relationships, employment, and community and civic life [42-44].

This is problematic because social connections provide purpose, foster resilience, and are linked to better health and quality of life [45-47]. Meaningful activities, such as volunteering or engaging in hobbies that involve interaction with others, can all contribute to a sense of belonging and social inclusion [10,11,48]. Moreover, both paid and unpaid employment, when provided under favorable conditions, increases self-esteem, self-efficacy, and overall life-satisfaction [49-51]. Paid employment enhances satisfaction with finances and fosters financial independence, thereby creating opportunities for full societal participation [52-54]. Active involvement in meaningful activities enables individuals to define themselves as active citizens, while a satisfactory social support network further promotes social inclusion and societal recovery [55]. In this dissertation, societal participation encompasses engagement in activities that involve interaction with others in society or the community, including paid or unpaid employment, education, interpersonal relationships, and meaningful daily, leisure, or civic activities [56].

However, employment rates among individuals with SMI vary from 10-20%, and from 15-40% when voluntary work is included in the definition [5,6,51,57]. Additionally, the social networks of individuals with SMI are typically smaller, and they report lower satisfaction and perceived social support compared to the rest of the population [7-9,58]. Studies also indicate that among individuals experiencing first psychotic experiences social networks decreased in both size and the perceived support from those social ties [7]. Furthermore, individuals with SMI tend to spend less time in meaningful daily activities and general productivity is lower than in the rest of the population [48,59]. Various factors contribute to these challenges, such as a lack of motivation due to specific medication, stigma and discrimination, or impaired cognitive abilities, notably executive functioning [48,59,60].

A growing body of research has investigated the effectiveness of interventions or approaches aimed at enhancing social inclusion [10,61-64]. There is strong evidence for Individual Placement and Support (IPS), Housing First, family psychoeducation, peer-led/supported interventions, and resource groups. However, evidence for improving social isolation through interventions focused on financial recovery is weak, and interventions focused on retention of family roles, satisfying relationships, or victimization lack sufficient evidence. Despite the existence of effective interventions, not all are widely available to every client in community mental health care. Therefore, more research is needed to adequately address the barriers to societal participation.

Stigmatization, discrimination, and victimization as barriers to societal participation

Stigmatization and discrimination

Discrimination is the behavioral aspect of the public stigma, i.e., labels, attached to mental illness, which lead to negative stereotypes and in turn to discriminative behavior [25,65]. To provide an example: “individuals may signal the public about their mental illness, for example, ‘that person talking to himself on the park bench must be crazy.’ These signals yield stereotypes about persons with mental illness: ‘crazy people are dangerous.’ Stereotypes lead to behavioral reactions or discrimination, for example, ‘I’m not going to allow dangerous people like that move into my neighborhood.’” [65(p.49)]. The internalization of these negative stereotypes can lead to self-stigma or internalized stigma, where individuals with SMI come to believe these stereotypes apply to themselves [25,66].

Numerous studies have shown that individuals with SMI experience a considerable amount of stigma and discrimination [13,16,67,68]. A comprehensive study among individuals with schizophrenia in 14 European countries found that nearly 42% of the participants reported experiencing self-stigma, while almost 70% reported encountering moderate to high levels of discrimination [68]. Another global study examined the prevalence of experienced and anticipated discrimination in the past 12 months [16]. Results showed that individuals with SMI experienced discrimination in various areas of life, including forming and maintaining friendships (47%), interaction with family members (43%), finding a job (29%), and sexual relationships (27%). In a Dutch panel survey among individuals with mental illness, one third reported feeling discriminated against due to their diagnosis, while a quarter experienced discrimination related to employment. Additionally, 20% refrained from certain activities due to the fear of negative reactions from others [69]. Several studies have explored the pathways linking stigma and discrimination. Strong and significant effects were observed between experienced discrimination and internalized stigma, as well as between experienced discrimination and anticipated discrimination (or anticipated stigma) [70]. Risk factors for experiencing discrimination include hospitalizations, more severe clinical symptoms, years in mental health services, being female, and anticipated stigma [14,67,71].

Victimization

Until recently, it was commonly believed that many individuals with SMI were inherently dangerous and prone to criminal behavior [72,73]. This stigmatizing perception was also reflected in scientific research, with several studies examining the link between mental illness and criminal behavior and concluding that individuals with psychiatric disorders were indeed more violent and dangerous than individuals without such disorders [74-77], with even recent studies reaching similar conclusions [19]. However, while perpetration rates are higher among individuals with SMI compared to the rest of the population, victimization rates among this group surpass perpetration rates [21,33,78].

Victimization encompasses various forms of crime, including violent crimes such as sexual and physical assaults, non-violent crimes like theft and burglary, digital crimes such as identity fraud or hacking, as well as other forms of abuse or exploitation [18,26]. For the purposes of this dissertation, victimization refers specifically to recent incidents occurring within the previous year. Individuals with SMI are more frequently victimized than other citizens in the Netherlands [79], a trend consistent with findings in the United States [34], often attributed to the (unintended) consequences of deinstitutionalization. In the United States, almost no one was initially prepared for the consequences of deinstitutionalization. As a result, intended benefits - emancipation and social integration - were largely overshadowed by the negative consequences, such as nuisance, neglect, poverty, homelessness, stigmatization, and marginalization of many individuals. Although deinstitutionalization occurred at a slower pace in the

Netherlands [80-83], studies from the US and Europe yield similar results regarding the high prevalence of victimization [17,18,21,32,34,84].

Dutch cross-sectional studies have reported prevalence rates ranging from 41.6–47% in the previous year, with prevalence rates for violent crimes (e.g., physical or sexual assault) ranging from 17.1–22.5% [17,24]. More robust research designs, such as cohort studies [85,86], population studies including siblings without mental illness [21,87], or studies utilizing individuals as their own controls [88], provide more informative and methodologically sound data. Although prevalence rates and relative risk may be slightly lower compared to cross-sectional studies, with an elevated risk of 3-6 times that of the rest of the population, the overarching conclusion remains: individuals with SMI face a higher risk of victimization across all crime types compared to the rest of the population. Furthermore, most perpetrators are familiar to the victims, often as family members, roommates, or neighbors) [23,24]. Often it does not stop at a single incident either. A large subgroup of individuals with SMI experiences multiple victimization incidents in relative short period of time [17,89], making them poly-victims. Poly-victims are victimized at least four times a year of different crimes. The prevalence is much higher among individuals with SMI, compared to the rest of the Dutch population (2% vs. 10% respectively) [17].

Several risk factors contribute to these heightened victimization rates. Women are more vulnerable to domestic and sexual offenses and violence, while men are more likely to experience violence [17,90]. Lack of stable housing, i.e., homelessness or sheltered living, is also associated with increased victimization rates [17,18,33,91]. Additionally, there is often an overlap between victimization and perpetration among individuals with SMI, known as the victim-offender overlap [92]. Adverse childhood experiences or childhood victimization may lead to both perpetration and victimization later in life [87,93]. Also, more recent victimization may serve as a catalyst for subsequent perpetration [94]. Complicating matters further, individuals may simultaneously be perpetrators and victims in the same incident. While the relationship between specific psychiatric diagnoses and victimization remains debated, some studies suggest higher victimization rates among individuals with schizophrenia or personality disorders, though findings are inconsistent [21,95,96]. One exemption is substance use disorder, as higher substance abuse is consistently associated with increased victimization rates [24], which can be explained by impaired responsiveness, or a decrease in the ability to assess or deal with potentially dangerous situations [32,74].

Impact on societal participation

Both discrimination and victimization entail negative experiences during social interaction, with far reaching consequences for social inclusion [27,70,95,97,98]. Self-stigma can lead to demoralization and subsequent loss of self-esteem or self-efficacy [29], potentially manifesting as the “why try” effect; where individuals with SMI internalize negative stereotypes, feeling unworthy or uncapable of pursuing opportunities for participation, ultimately leading to social avoidance (‘Why should I even try to get a job? Someone like me − someone who is incompetent because of mental illness − could not successfully accomplish work demands.’ [29(p.76)]). The “why try” effect is corroborated by evidence showing that experiences of rejection (experienced discrimination) can deter individuals from pursuing life opportunities, potentially resulting in withdrawal from community life [16]. In essence, discrimination contributes to demoralization and diminished well-being through internalized and anticipated stigma [70,99].

Moreover, violent victimization poses a risk to social functioning; interpersonal violence (both expressed and experienced) emerges as the primary predictor of deteriorated social functioning [98]. Additionally, (repeated) victimization within one’s close social network has an enormous impact on a person’s trust in others, one’s self-esteem and self-efficacy [18], potentially jeopardizing current and future social relationships and prompting social withdrawal and a decreased quality of life [18,26]. This relationship tends to be reciprocal. While a stable and dense support system can act as a protective factor, residing in an impoverished social environment, associating with a criminogenic social network, or engaging in conflicted social relationships may heighten the risk of both victimization and perpetration [97,100]. Furthermore, individuals who lack meaningful daily activities are more susceptible to victimization, irrespective of the presence of positive or negative symptoms [95]. Additionally, similar to anticipated stigmatization, the fear of or anticipation of victimization, or the feeling of unsafety, can detrimentally impact self-esteem, self-efficacy, and can lead to social withdrawal [101].

To our knowledge, only a few studies have concurrently examined victimization and discrimination in relation to the impact on societal participation [102,103]. Nevertheless, these studies offer insights into the interplay among victimization, stigma, discrimination, and societal participation. Horsselenberg et al. [103] suggested that among people with schizophrenia spectrum disorders victimization induces negative self-esteem through self-stigma. Additionally, only positive symptoms (vs. negative symptoms) impacted self-stigma through victimization. Similarly, Ruijne et al. [102] found that both personal and property victimization influenced social withdrawal (measured as anticipated stigma) through experienced discrimination, with personal victimization also exerting a direct effect on social withdrawal. The researchers of both studies argue that interventions targeting victimization or stigma and discrimination directly have the potential to enhance societal participation.

Community mental health care in the Netherlands

The Dutch mental health care landscape has shifted significantly since the 1980s. Previously dominated by inpatient care, the system has transitioned towards community-based treatment [43,104]. Today, individuals with SMI receive mental health support or care in specialized clinics, supported housing accommodations, and primarily through outpatient services [43]. This shift aims to promote rehabilitation and recovery by allowing individuals to seek employment, maintain social roles, and live more autonomously. However, challenges remain in ensuring successful integration into society [105].

Flexible Assertive Community Treatment (FACT)

Developed in the US [106], Assertive Community Treatment (ACT) was introduced in the Netherlands during the 2000s [107]. However, concerns regarding its application led to the development of the Flexible Assertive Community Treatment model. Firstly, implementing ACT teams in rural areas with few eligible clients proved challenging due to vast distances hindering continuity of care [108]. Secondly, ACT was designed for the most vulnerable 10-20% of individuals with SMI at risk of relapse or crisis, leaving the remaining 80% served by case management teams, posing difficulties for professionals when clients experienced relapses [109].

By 2020, FACT had become the dominant model with around 300-400 certified teams, compared to just 35 ACT teams and 80 FACT teams in 2011 [107,110]. FACT provides continuous care throughout periods of crisis and stability. The multidisciplinary and rehabilitative aspects are crucial for all individuals with SMI, as successful rehabilitation during relatively stable periods is more achievable [109]. Similar to ACT, FACT teams are multidisciplinary, typically managing a caseload of around 200 clients with each case manager responsible for 15-25 clients [111]. Clients receive support across various life domains, such as housing, finances, education, employment, social contacts, with treatment goals tailored to these areas evolving over time. When there is a risk of relapse, care is intensified, with clients placed on a shared whiteboard / digiboard for the entire team to collaborate on preventing relapse and/or readmission.

Recovery-oriented care and the Boston University Approach to Psychiatric Rehabilitation (BPR)

The FACT model aims to support clients throughout their recovery journey. While studies have shown its positive impact on reducing hospital readmissions through continuity of care [112], recent findings showed that FACT teams performed inadequately on the fidelity items linked to participation, rehabilitation, and recovery [113]. This suggests a need for stronger support for societal recovery alongside clinical recovery within FACT teams.

Several rehabilitation methods have been implemented to address this gap. Psychiatric rehabilitation, defined as supporting individuals in societal recovery by focusing on "the skills and environmental supports (psychiatrically disabled persons need) to fulfill the role demands of various living, learning, and working environment" [114(p.549)], has gained increasing emphasis in recent years [3]. However, initial FACT teams often prioritized clinical recovery over daily activities and social relationships [115]. A few interventions worth mentioning here have been incorporated into FACT, including individual placement and support (IPS) to enhance employment outcomes [116], the resource group method involving significant others in treatment [117,118], Peer-supported Open Dialogue which emphasizes network mobilization [119], and the network approach “Netwerkzorg” that focuses on collaboration across domains and peer support [110].

While FACT teams employ various rehabilitation methods further attention is needed to improve implementation fidelity. These methods include interventions targeting specific life domains (e.g., IPS and Supported Education) and broader approaches addressing multiple life domains (e.g., Strengths Model, CARe methodology, BPR [120-122]).

The BPR, guides mental health professionals in facilitating, supporting, or teaching clients to attain preferred and valued roles. An important aspect of the approach is its person-centered focus and the belief that every individual has the capacity to learn, grow, and take control of their own lives and care (i.e., autonomy) [120]. The approach involves a cyclical process with distinct phases: exploring (identifying goals), choosing (specifying goals), getting (taking action), and keeping (sustaining progress) [120,123]. In the Netherlands, the leading training institute for the BPR is ‘Stichting Rehabilitatie ’92’ (R92).

Studies on the BPR have yielded mixed results, with some demonstrating positive effects on quality of life and goal attainment, while others showed no significant difference compared to non-systematic approaches [124-129]. However, the BPR offers a structured framework for promoting societal recovery compared to no systematic approach, despite the need for improved implementation fidelity and inconclusive evidence on its effectiveness for societal recovery [130,131].

Addressing victimization in FACT teams

With the rise of recovery-oriented care and the client movement, attention has shifted towards the significance of self-determination and the exploration and pursuit of possibilities. However, there are limited appropriate responses regarding how to balance the dilemma of supporting safe participation versus self-determination in community mental health care [132].

Firstly, the FACT model offers some insights but does not specifically address victimization. FACT team audits assess adherence to model standards, including one item on staff-related stigma and self-stigma in clients [113]. Although several items related to risks and safety are included in the audit, these primarily focus on client-initiated offenses. Additionally, teams are evaluated on societal participation, requiring awareness of the client’s roles within domains such as ‘social network’ and ‘employment and leisure,’ with visible interventions mandated [113].

Secondly, the BPR provides guidelines for overcoming barriers to societal participation, unlike other general rehabilitation methods. The target skill or readiness module is particularly useful for identifying barriers to societal participation and is employed when a client shows insufficient progress in one of the BPR phases [123]. While the model offers tools to assess the client's readiness for action, victimization is a blind spot herein, lacking specific focus. Nevertheless, it lays a solid foundation for integrating this theme.

Historically, mental health professionals have the responsibility to intervene in high-risk situations for clients with impaired capacity. However, this applies to only a small minority of the clients, and not always. This responsibility has fostered a risk-averse culture, where clients are assessed on the dangers they pose rather than their wishes and needs [133]. This contradicts a recovery-oriented approach, as discouraging clients from taking responsible risks, hampers them to move forward in recovery [132]. Additionally, many professionals fear that discussing victimization will create more stress, inflict (more) trauma, or exacerbate psychiatric symptoms [31,134]. Research suggests otherwise. A large study involving individuals with psychosis, found that discussing trauma and recent victimization incidents had no adverse effects and even reduced re-victimization [134]. Clients themselves often downplay victimization or hesitate to discuss it with their mental health professionals [84,135].

Research shows that discussing the impact of victimization experiences can benefit societal recovery [136,137]. Holley et al. [31] propose that risk management and recovery-oriented care can coexist. Adopting a positive risk approach empowers clients to take responsibility for their recovery and manage risks. Recovery-oriented care emphasizes fostering hope, self-control, choice, empowerment, and personal growth [138]. Safety remains important, but taking risks should not be viewed solely negatively, as they are crucial for individuals with SMI to pursue possibilities.

The consumer movement's concept of dignity of risk underscores every individual's right to take reasonable risks to progress in life. Overprotecting or discouraging individuals with SMI from taking these risks may diminish hope and future perspectives [30]. This concept has been translated into guidelines for US mental health professionals, emphasizing community integration as the road to recovery, including promoting the dignity of risk: "There is an inherent risk in almost everything we do in our lives. This should not exclude us from participating, but rather ensure that we properly plan to mitigate the harm that can be associated with the various domains and life activities" [136(p.17)]. However, this approach was not widely implemented or tested for its effectiveness.

While studies support the importance of recognizing and acknowledging the impact of victimization and accompanying fear and other emotions [139-141], there is a lack of interventions that effectively address both these risks and the concept of dignity of risk within community mental health care settings. Consequently, it remains unclear whether adopting a positive risk approach leads to greater community integration.

Aim and outline of the dissertation

Given the identified need for greater insight, this dissertation focuses on promoting participation by mitigating victimization. Mental health professionals in particular, require guidance on striking a balance between supporting safe participation and respecting the right to take reasonable risks. As such, the primary aim of this dissertation is twofold: firstly, to gain insight in the variation in victimization, perpetration, experienced discrimination, and social functioning rates among individuals with SMI, thereby enhancing understanding of the factors contributing to reducing these barriers to participation; secondly, to develop and evaluate a victimization-informed intervention, assessing both its implementation process and effectiveness in reducing victimization, enhancing recognition and coping mechanisms, and consequently fostering societal participation.

The corresponding research questions are as follows:
1. Which profiles exist among outpatients with SMI based on their experiences of victimization, perpetration, experienced discrimination, and social functioning, and do these subgroups differ in terms of socio-demographic factors, psychiatric diagnosis, social support, self-efficacy, and quality of life?
2. What components should be incorporated in a new intervention aimed at addressing and mitigating the impact of victimization to promote (safe) societal participation?
3. Does the application of this newly developed intervention result in decreased victimization and increased societal participation compared to care as usual (CAU) among individuals with SMI receiving outpatient treatment?
4. To what extent is the Victoria intervention implemented as intended, what factors influence its implementation, what impact does the intervention have on individuals with SMI, and how is this new intervention perceived by mental health professionals?

Initially, little was known about the impact of victimization on societal participation and its variability across outpatients with SMI. Therefore, **Chapter 2** presents the findings of a latent class analysis involving victimization, perpetration, experienced discrimination, and social functioning. Additionally, differences between these classes on socio-demographic, clinical, and person-related variables are explored. **Chapter 3** delineates the iterative process of developing and piloting the Victoria intervention and its accompanying training module. **Chapter 4** outlines the design of the cluster randomized controlled trial, including a process evaluation. **Chapter 5** presents the results of the cluster randomized controlled trial, examining the effectiveness of the Victoria intervention on victimization, social participation, acknowledgement of difficulties, self-efficacy and empowerment, quality of life, and psychosocial functioning. **Chapter 6** discusses the results of the process evaluation to gain deeper insights into the trial effects. Finally, **Chapter 7** offers a reflection on the main findings, including methodological considerations, exploration of potential practical implications, and recommendations for future research.

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2

Profiling of victimization, perpetration, and participation

A latent class analysis among people with severe mental illness

Published as:
Albers, W. M. M., Roeg, D. P. K., Nijssen, Y., van Weeghel, J., & Bongers, I. M. B. (2018). Profiling of victimization, perpetration, and participation: A latent class analysis among people with severe mental illness.

PLoS One. 2018;13(11):e0208457.

Abstract

Background
Persons with severe mental illness are more prone to victimization and experience more difficulties regarding societal participation than other community members. These experiences vary greatly among individuals. Community mental health care should offer more individualized support by addressing these differences in experience. Therefore, this study aimed to identify subgroups of outpatients with severe mental illness based on their experiences of social participation and victimization.

Methods
Data from patients with severe mental illness from eight outpatient teams in the Netherlands were used to perform latent class analysis. 395 patients were included in the analyses. Classes were based on: i) criminal victimization incidents, ii) criminal perpetration incidents (Dutch Safety Monitor), iii) experienced discrimination (DISC-12), and iv) social functioning (Social Functioning Scale). Also, to investigate differences between the classes, socio-demographic, clinical, and person-related variables were examined.

Results
Three classes were identified. The “Victimized and Perpetrating class” (34.4%) had the highest prevalence of discrimination, victimization, and perpetration, and intermediate scores on social functioning subscales. This class also experienced the most problems in other domains, such as psychosocial functioning and quality of life. The “Discriminated and Avoiding class” (36.4%) had moderate scores for discrimination, victimization and perpetration, and the lowest scores for social functioning and social support. The “General Difficulties class” (28.8%) had the lowest prevalence of discrimination, victimization, and perpetration, and the highest scores on social functioning.

Discussion
These distinct classes offer new insights to mental health professionals in outpatient teams in in their aim to positively influence the patient’s social context during rehabilitation; this includes addressing the role of victimization, and indicates the relevance of distinctive approaches and the support needed for each class. Professionals may need to focus more on the impact of difficulties in their patients’ social context to adequately support them in the rehabilitation process.

Keywords
Victimization, perpetration, social participation, severe mental illness, discrimination, stigma, latent class analysis

Introduction

People with severe mental illness are more likely to become a victim of crime than other citizens [1-4]. Studies in the Netherlands have reported prevalence rates for all types of crime victimization, ranging from 41.6-47% for outpatients in the previous year [2-5], whereas for violent crimes (e.g., physical or sexual assault) prevalence rates range from 17.1-22.5% [2-5]. When persons with severe mental illness experience criminal victimization, the number of incidents is often higher than for other citizens, i.e., they are more often a poly-victim [2]. Furthermore, most crimes tend to be committed in the individual's own home. Correspondingly, the majority of perpetrators are familiar to the victim, e.g. it is often the (ex-)partner, neighbor, or roommate in the housing facility or inpatient setting [6,7]. Criminal victimization can have long-term consequences and may harm a person's trust in others, impair social relationships, and negatively affect their quality of life [4]; moreover, the accumulation of criminal victimization (poly-victimization) often indicates the accumulation of problems on other life domains [8].

In addition, individuals with severe mental illness are more likely to be perpetrators of a crime than members of the general population [1,9]. However, for some individuals with severe mental illness, the roles of victim and perpetrator are interwoven, often making this relationship more complex than generally realized. A few studies have examined the association between victimization and perpetration in the same sample of persons with severe mental illness [9-11]. Childhood victimization may lead to perpetration later in life, and there is a strong overlap between victims and perpetrators. An individual may even be a victim and perpetrator in the same incident, making it difficult to unravel what has contributed to becoming a victim or a perpetrator [12].

Besides criminal victimization, people with severe mental illness also experience a considerable amount of discrimination and stigmatization. Brohan et al. [13] found that almost 70% of their sample perceived discrimination. Similar to victimization, the experience of discrimination can seriously affect an individual in their daily activities [13,14], both leading to a lower quality of life, lower self-esteem, avoidance of social interaction (i.e., the "why try" effect), unemployment, and an increase in symptoms [13-16].

It remains unclear how frequently discrimination and stigmatization occur together with victimization and perpetration in persons with severe mental illness and how these individuals participate socially. In particular, little is known about how victimization, perpetration, discrimination, and stigmatization interact in different groups of individuals with severe mental illness, or how this is related to social participation within these groups. Identifying these different patterns of victimization in community living, and their relationship with social functioning, is important for mental health professionals when supporting patients in their rehabilitation trajectories.

Although several psychiatric rehabilitation methods have been implemented and have shown significant improvements in role functioning and life satisfaction [17-19], many individuals with severe mental illness still face unemployment, poverty, social isolation, criminal offending, and victimization [20,21]. Moreover, despite the high rates of victimization among individuals with severe mental illness and the consequences of this in their daily lives, this is rarely a structural topic of conversation in community-based mental health teams [22,23]. It is reported that trauma treatment in a wider range of patients is more effective than previously thought [24]. Less recognized is the effect of the difficulties and traumatic events that persons with severe mental illness encounter throughout their lives. It can be assumed that incidents of victimization and discrimination form a serious threat for participation and personal recovery [25]. Thereafter, increased understanding, acknowledgement of the adverse experience, and the learning of coping skills will better prepare individuals with severe mental illness for possible risks in future situations [26,27].

Therefore, this study aimed to identify conceptually cohesive profiles in outpatients with severe mental illness based on their experiences of victimization and perpetration, discrimination and stigmatization, and social functioning. Our hypothesis was that we would find variations in victimization, perpetration, experienced discrimination, and social functioning rates. Furthermore, we expected these groups to vary in terms of socio-demographic, psychiatric, and other variables, such as social support, self-efficacy, and quality of life.

Materials and methods

Participants

In the current mental health care system in the Netherlands, many people with severe mental illness receive outpatient care from flexible assertive community treatment (F-ACT) teams. The F-ACT model is a flexible mode of ambulatory care delivery which allows to switch from crisis management or assertive community treatment to multidisciplinary treatment and individual case management when necessary [28]. In the present study, eight F-ACT teams from two mental health organizations participated; three teams were located in the north-west of the Netherlands and five in the south. Four teams had an urban catchment area, two were based around small cities, and two were in rural areas. Inclusion criteria for this study were: having a severe mental illness, according to the Diagnostic and Statistical Manual of Mental Disorders-IV (DSM-IV), aged ≥ 18 years, and willing to participate. Exclusion criteria were: aged < 18 years, insufficient comprehension of the Dutch language, unable to complete the interview due to cognitive impairment, florid psychosis or psychiatric crisis (i.e., having a serious relapse), psycho-organic disorder, and prolonged admission to psychiatric hospital or prison. From the eight teams (caring for 1527 patients), 133 patients met the exclusion criteria and the remaining patients (*n* = 1394) were eligible to participate.

Finally, 408 outpatients met the inclusion criteria and agreed to participate; these individuals were interviewed between March and August 2016. The response rate of 27% is similar to that of a large national Dutch study on victimization conducted by Kamperman et al., i.e., 29% [2]. Of the recruited 408 patients, 395 were finally included in the analyses; the 13 excluded patients had missing data on (at least) one of the primary outcome variables.

Procedure

This study is part of a cluster randomized controlled trial in which the effectiveness of a novel intervention for victimization and societal participation was assessed. The study protocol was approved by the Medical Ethical Committee of the Elisabeth Hospital in Tilburg (NL53845.028.15) for all participating sites. The study was registered in the Dutch Trial Register (NTR 5585).

All patients received a letter and brochure with information about the trial, including details on the themes and timeframe of the study. All participants could withdraw from participation at any time for any reason. After a two-week consideration period, patients were contacted to provide them with more information (if required) and to ask if they were still willing to participate. When the patient agreed to participate, written consent was requested before the start of the interview. If the patient declined participation, this had no consequences for the care they received.

Data were collected during face-to-face structured interviews in a location of the participant's choice, e.g., the patient's home or the F-ACT office. Regular checks were made with the patient's mental health professional to confirm whether the home environment was a safe place for the interview to take place (for both the patient and interviewer). Each interview lasted on average 75 minutes, after which the patients received a small financial compensation. In addition, the main mental health professional for each participating patient filled out a brief questionnaire, including the information described below (see 'Measures').

Measures

To determine the classes, four concepts were taken into consideration: i) experienced discrimination, ii) victimization, iii) perpetration, and iv) social functioning. These measurements were chosen according to their usage in (inter)national mental health research and their acceptable psychometric properties.

Experienced discrimination was assessed by the Discrimination and Stigmatization Scale (DISC-12) [29]. The scale 'unfair treatment', or experienced discrimination, contained 22 items (α = 0.82). All items were answered on a four-point scale ranging from 'no difference' (0) to 'a lot' (3). A 'not applicable' answer was available when the participant was not involved in the described situation. Scores on the 22 items were summed, and a mean score was used in the analyses (minimum = 0, maximum = 2). Inter-rater reliability ranged from 0.62-0.95. Overall reliability was also adequate (α = .78) [29].

Anticipated stigmatization and overcoming stigmatization were also measured with the DISC-12. Anticipated stigmatization contained four items, and overcoming stigma two items. For each scale, all scores were summed and a mean score was used in the analyses.

Victimization was measured using the Dutch Safety Monitor, developed by the Dutch Ministry of Security and Justice [30], which is similar to the International Crime Victimization Survey [31]. In this larger Dutch questionnaire, the victimization section contains 15 crime incidents: burglary, theft from car, car theft, theft of other motorized vehicles, bicycle theft, (attempted) robbery, theft (other than previously categorized), sexual intimidation or assault, threats (of violence), physical assault, vandalism, identity fraud, fraud with buying/selling items/services, hacking, and cyber bullying. Car and motor theft items were not included in the scores on victimization because only very few participants owned a vehicle. For each incident, the participant was asked whether this had happened in the last year, *yes* (1), or *no* (0). All scores were summed , and a sum score (minimum = 0, maximum = 7) was used in the analyses. Although the Safety Monitor is the largest safety survey used in the Netherlands, and is the most reliable measure available, psychometrics were not available as the questionnaire is updated yearly and used for annual monitoring. Poly-victimization was defined as experiencing four or more different types of incident in the last 12 months [32], and was calculated for patients that reported at least one victimization incident during the last 12 months.

Perpetration was also assessed with the Dutch Safety Monitor. Regarding incidents of victimization, participants were asked whether they had been a perpetrator in the previous year. A sum score (minimum = 0, maximum = 7) was used in the analyses.

Social Functioning was measured using the Social Functioning Scale (SFS) [33]. This tool measures social functioning in seven domains: social engagement/withdrawal (time spent alone, initiation of conversations, social avoidance), interpersonal behavior (number of friends, quality of communication), pro-social activities (engagement in a range of common social activities), recreation (engagement in a range of common hobbies or interests), independence-competence (ability to perform skills necessary for independent living), independence-performance (performance of skills necessary for independent living), and employment/occupation (engagement in employment or structured daily activities). The SFS has good internal consistency (α = .80) [33]. Item scores on all seven domains were summed, and a sum score (minimum = 574.50, maximum = 891.50) was used in the analyses.

Additionally, we included the following measures to further describe the classes.

Information from the main mental health professional: **general psycho-social functioning** was measured with the Health of the Nation Outcome Scale (HoNOS) [34]. This scale contains 15 items on which the professional scored the patient's functioning on a scale ranging from '*no problems*' (0) to '*a lot of problems*' (4); a sum score was included in the analyses. The intra class correlation coefficient was .92, and the Cronbach's alpha for the overall scale is .78 [35]. The mental health professionals were also asked to report the patient's registered **psychiatric diagnosis** according to the DSM-IV, which was the DSM version used during inclusion. Clusters of diagnoses included in the analyses were: schizophrenia, other psychotic disorders (i.e.,: brief psychotic disorder, delusional disorder, psychotic disorder due to a general medical condition, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, and substance-induced psychotic disorder), mood disorder, anxiety disorder, developmental disorder, substance use disorder, other Axis 1 diagnoses (i.e., in this sample: cognitive disorder, dissociative disorder, eating disorder, intermittent explosive disorder, pedophilia, alcohol-induced persisting amnestic disorder, impulse-control disorder, and somatization disorder), and personality disorder. All professionals received training on this instrument to enhance interrater reliability, as recommended by Ventura et al. [36]. The mental health professional was also asked to report whether the patient was **avoiding or stagnating in societal participation** on a scale ranging from (0) '*not at all*' to (3) '*yes, definitely*'.

Two other measures from the Dutch Safety Monitor were **general feeling of unsafety**, answered with '*yes*' and '*no*', and **the expectation of becoming a victim in the next 12 months**, which was answered on a five-point scale ranging from '*a really big chance*' to '*a really small chance*'.

Social support was derived from the Inventory of Social Reliance (ISR) [37]. This consists of 11 items on emotional and practical support scored on a four-point scale ranging from 'almost never' to 'almost always'; a sum score was included in the analyses. The ISR is a frequently used questionnaire for individuals with severe mental illness and has good psychometric properties [37].

Quality of life was measured with the Manchester Short Assessment of Quality of Life (MANSA) [38]. The MANSA consists of 12 questions scored on a seven-point Likert scale ranging from 'couldn't be worse' to 'couldn't be better' and four questions that are answered with yes/no. Internal consistency is good ($\alpha = .81$) [39]. Mean scores were included in the analyses.

Self-efficacy in mental health-related beliefs was measured with the Mental Health Confidence Scale (MHCS) [40], using a six-point Likert scale, ranging from 'totally no confidence' to 'full confidence'. A sum score was included in the analyses. Cronbach's alpha for the total scale is .91 [40].

Sociodemographic characteristics. The following socio-demographic variables were measured: age at the time of participation, gender (*male* '0', *female* '1'), ethnicity (born in the Netherlands or not), living situation (*living with family, on their own, supported living, other*), marital status (*married, not married, divorced, widow, cohabitation agreement*), and employment status (*benefits, retired, employed, other*).

Statistical analyses

Latent class analysis (LCA) was conducted to determine the underlying latent structure of the data. Although this is comparable to confirmatory factor analysis [41], in LCA the persons are grouped, rather than the items. We tested a series of latent class models (one to seven classes) to determine which model fitted the data best. Several indices were used to determine the model that best fitted the structure of the data and that were also theoretically and practically relevant.

First, the Bayesian information criterion (BIC) and the Akaike information criterion (AIC) with a penalty factor of three (AIC3) were used as goodness-of-fit indices [41,42]. It was found that, in studies with few indicators and a moderate to large N, AIC often selects an unnecessarily complex model, making AIC3 a better alternative [43]. BIC was also included and was found to be a consistent information criterion in LCA [41,43]. For both measures, lower values indicate a better fit of the model to the data.

Second, bivariate residuals were included to determining the number of classes to check for violation of the assumption of local dependencies between the included variables on which the clusters were based (i.e., discrimination, victimization, perpetration, and social functioning). If bivariate residuals are > 4, this implies that this assumption is violated [44].

Finally, class probabilities for the suggested solution were examined. The classification error was also considered, i.e., the chance that a patient was assigned to the wrong class. Thus, the ultimate class solution was based on the goodness-of-fit of the indices, classification errors, and bivariate residuals.

After identifying the number of classes, bias-adjusted three-step LCA was conducted to determine whether classes differed in sociodemographic, clinical, or other characteristics. This type of analysis consider the probability of belonging to all classes and, therefore, corrects the classification error [45]. Within this type of analysis, the 'dependent option' is an ANOVA-like test to examine differences across classes. Moreover, paired comparisons with a Wald-statistic were used to evaluate differences between pairs of groups. The LCA and other analyses were performed with Latent Gold 5.1 [41]. A significance level of .05 (two-tailed) was used for all tests.

Results

Sample characteristics

In the total sample (*N* = 395), the mean age was 45.4 (*SD* = 9.78) years, with 59% in the age range 30-50 years; 40.3% of the patients were female, 83.5% were born in the Netherlands, 80.2% lived independently, and 14% had paid employment (see 'Full sample' columns in Tables 2-5). The majority of the participants were diagnosed with schizophrenia (26.8%), another psychotic disorder (24.6%), or personality disorder (14.7%). Analyses showed no significant difference between the respondents and non-respondents regarding age, gender, mental health care center, and F-ACT team.

Latent class analysis

Firstly, model fit statistics were examined (Table 1). Although the AIC3 decreased with an increasing number of classes, the differences were small (± 10) after the fourth class, indicating that a more complex model offered no additional value. In the three-class solution, the BIC had the lowest value in the three-class solution.

Table 1. Fit indices for latent class analysis (*N* = 395)

No. of classes	Log-likelihood	BIC (LL)	AIC3 (LL)	Entropy R^2	No. of parameters	Classification error
1	-3156.423	6414.487	6363.845	-	17	0.000
2	-3027.020	6197.533	6126.040	0.682	24	0.089
3 *	-2989.221	6163.788	6071.443	0.650	31	0.159
4	-2968.819	6164.837	6051.639	0.668	38	0.177
5	-2953.612	6176.274	6042.224	0.695	45	0.170
6	-2938.454	6187.810	6032.908	0.729	52	0.182
7	-2919.470	6191.695	6015.940	0.754	59	0.184

* Selected model

Secondly, in all calculated clusters, bivariate residuals for victimization and perpetration were above four. Although the most straightforward solution would have been to increase the number of clusters to an eight-cluster model or higher, this would have led to a small n per cluster, which was undesirable. Another solution was to allow for local dependencies between these two variables [41]. Correlation between perpetration and victimization was allowed, based on Choe et al. [1]. By allowing residuals to correlate, the three-class model provided the best solution (BIC = 6163.79, classification error = 0.159).

Finally, class probabilities for the three-class solution were high (averaging 0.79-0.91), indicating that individuals were assigned to the correct latent class. The three-class model was the most appropriate model, considering model fit statistics and theoretical implications.

Description of the classes

A plot of the estimated probabilities of the three classes is presented in Figure 1 and the probabilities and scores of each item are given in Tables 2 and 3.

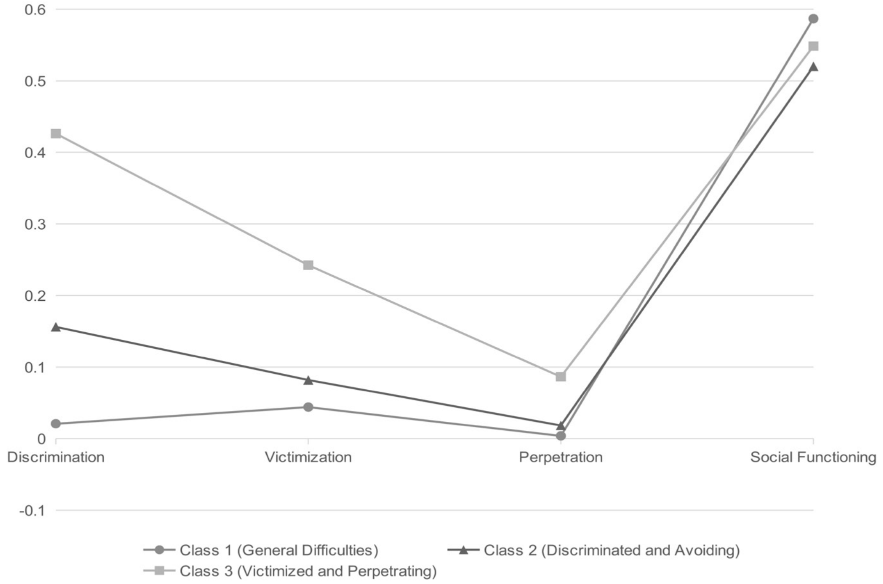

Figure 1. Profiles of the three classes based on discrimination, victimization, perpetration, and social functioning. (Standardized scores, $N = 395$)

This first class ($n = 114$, 28.8%) experienced the lowest number of victimization incidents: 25% of this class had experienced one or more incidents in the past year (vs. 18% of the general population in 2015) and were (almost) never a perpetrator of an incident. Furthermore, 5.9% of the individuals in this class had experienced a personal victimization incident, compared to 2.2% of the remainder of the population [30]. For property victimization, these data are 8.8% and 12.2%, respectively. Therefore, this class is labelled the *"General Difficulties* class". This class had the highest scores on the social functioning subscales 'interaction' and 'pro-social'. In terms of anticipated discrimination, members of this class had significantly lower scores than the other classes.

The second class (*n* = 145, 36.8%) had a higher prevalence rate of experienced discrimination than the first class. In particular, this class had the lowest scores on overcoming stigmatization; this implies that individuals in this group felt they had the least skills in coping with discrimination. This class was further characterized by the lowest scores on all three social functioning subscales ('interaction', 'recreation', and 'pro-social'), which differed significantly between the classes. This class is labelled the "Discriminated and Avoiding class".

The third class (*n* = 136, 34.4%) had the highest prevalence of victimization and perpetration, and also had the highest scores for experienced discrimination and anticipated stigmatization. On the other hand, this class had the highest scores for overcoming stigmatization and on the 'recreation' subscale of social functioning (which contained items on the number of times the patient had read, repaired things, shopped, played an instrument, etc.). The average number of victimization incidents per year was 1.7 for this group (S1 Table), and > 50% of this class had experienced one or more personal victimization incidents in the previous year (including threats of violence, violence, and sexual intimidation/assault) as compared to < 10% in the other two classes. This class is labelled the "Victimized and Perpetrating class".

Table 2 also gives the prevalence rate of poly-victimization in the three classes. For the "Victimized and Perpetrating class", this means that of the group that reported one or more victimization incidents, 20.5% can be defined as a poly-victim. This accounts for 17.5% of the total "Victimized and Perpetrating class" (S2 Table).

Table 2. Victimization and perpetration items per class

	Full sample	Class 1: General Difficulties class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N = 395)	(n = 114) (28.8%)	(n = 145) (36.8%)	(n = 136) (34.4%)	Wald	p value	Group differences [a]
Property victimization	19.2%	8.8%	9.4%	38.6%	29.428	.000*	V>G,D
Personal victimization	21.5%	5.9%	7.1%	50.1%	46.897	.000*	V>G,D
Digital victimization	15.7%	3.4%	5.9%	36.4%	34.074	.000*	V>G,D
Poly-victimization [b]	10.8%	2.3%	0.0%	20.5%	200573.313	.000*	D<G<V
Total victimization	46.8%	24.8%	39.6%	73.0%	23.682	.000*	V>G,D
Property perpetration	5.1%	0.0%	2.7%	12.1%	13601.182	.000*	G<D,V
Personal perpetration	11.4%	0.9%	0.6%	31.7%	12.734	.002*	G<V
Digital perpetration	10.1%	5.6%	6.4%	17.9%	8.594	.014*	V>G,D
Total perpetration	17.5%	2.6%	11.3%	36.5%	8.799	.012*	V>G
Anticipated stigmatization (DISC-12) [c]	0.812	0.493	0.723	1.177	35.270	.000*	V<G<D
Overcoming stigmatization (DISC-12) [c]	1.186	1.192	0.898	1.488	15.055	.001*	G<V, D>V

Note: *p* value of Wald statistic,

* *p* < .05

[a] G: *General Difficulties* class, D: *Discriminated and Avoiding* class, V: *Victimized and Perpetrating* class, ns: no significant paired comparisons

[b] Poly-victimization is presented as 'victimization of which poly-victimization' (*n* = 185)

[c] Mean scores are presented (minimum = 0, maximum = 3)

Table 3. Social functioning items per class

	Full sample	Class 1: General Difficulties class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N = 395)	(n = 114) (28.8%)	(n = 145) (36.8%)	(n = 136) (34.4%)	**Wald**	**p value**	**Group differences** [a]
Engagement	92.11	93.84	91.08	91.76	5.925	.052	D<G
Interpersonal	118.71	124.75	115.04	117.57	13.243	.001*	G>D,V
Independence - performance	109.74	111.40	107.81	110.40	5.658	.059	D<G
Recreation	114.47	114.85	110.81	118.08	7.686	.021*	D<V
Pro-social	105.14	108.00	101.09	107.08	10.800	.005*	D<G,V
Independence - competence	107.28	109.28	106.36	106.58	5.541	.063	G>V
Occupational	102.62	104.11	102.35	101.65	1.269	.530	ns

Note: *p* value of Wald statistic,
* $p < .05$
[a] G: *General Difficulties* class, D: *Discriminated and Avoiding* class, V: *Victimized and Perpetrating* class, ns: no significant paired comparisons
For each subscale sum scores are presented, with 100 being set as an average for patients with SMI.

Differences in socio-demographic, clinical, and person-related variables

Of the sociodemographic variables, significant differences were found in age and living situation (Table 4). The "Victimized and Perpetrating class" contained the youngest persons (mean age 41.9 years), followed by the "General Difficulties class" (mean age 46.9 years), and the "Discriminated and Avoiding class" (mean age 47.5 years). Regarding the living situation, although the differences were small, the "Discriminated and Avoiding class" contained the most individuals that lived independently.

Diagnosis (Table 4) and psychosocial functioning (HoNOS) (Table 5), both filled out by the patient's mental health professional, showed a significant difference between the three classes. Individuals in the "General Difficulties class" were significantly more likely to have schizophrenia or another psychotic disorder as a primary diagnosis compared with the other two classes. Although in the "Discriminated and Avoiding class" the highest percentage also suffered from schizophrenia (30.8%), individuals in this class were more likely to suffer from mood disorders (21.6%) and developmental disorder (13.6%) than those in the other two classes. In the "Victimized and Perpetrating class", schizophrenia as a primary diagnosis was the least common of all the classes (13.8%). Most individuals in this class had a personality disorder, psychotic disorder (other than schizophrenia), or an anxiety disorder (including post-traumatic stress disorder) as a primary diagnosis.

With regard to the overall score on the HoNOS, the "Victimized and Perpetrating class" had the highest score, indicating that they experienced the most problems in all life areas. Analysis of the specific items of the HoNOS (aggression, substance use, depression, personal relationships, residential problems, and motivation for treatment problems) showed a significant difference between the three classes. Again, on all these items, the "Victimized and Perpetrating class" had the most problems. The "Victimized and Perpetrating class" also scored the highest on stagnating on societal participation (assessed by the mental health professionals, implying that they experienced the most difficulties in participating socially and/or being socially active.

Regarding experienced social support, the "Discriminated and Avoiding class" scored significantly lower than the "General Difficulties class", implying that individuals in this class experienced less social support (both emotional and practical). This was in line with the low scores on social functioning for this class.

Table 4. Characteristics of patients with regard to the full sample and the three classes

	Full sample	Class 1: General Difficulties -class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N=395)	(n=114) (28.8%)	(n=145) (36.8%)	(n=136) (34.4%)	Wald	p-value	Group differences [a]
Age (mean) in years	45.4	46.9	47.5	41.9	18.404	0.000*	V<G,D
Female	40.3%	38.3%	40.6%	41.6%	0.229	0.890	ns
Born in the Netherlands	83.5%	83.7%	84.0%	83.0%	0.036	0.980	ns
Living situation							
Living with parents or family	4.3%	6.2%	2.2%	5.1%	2501.169	0.000*	
Living on their own	80.2%	80.2%	82.1%	78.0%			
Supported (independent) living	14.5%	13.6%	15.0%	14.6%			
Other	1.0%	0.0%	0.8%	2.3%			
Marital status							
Not married	66.5%	74.0%	62.8%	64.3%	9.505	0.300	ns
Divorced	16.2%	13.3%	12.6%	22.7%			
Married	14.0%	10.1%	19.3%	11.4%			
Widow/widower	2.0%	0.9%	3.9%	1.0%			
Cohabitation agreement	1.3%	1.8%	1.5%	0.7%			
Employment status							

Table 4. *Continued*

	Full sample	Class 1: General Difficulties -class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N=395)	(n=114) (28.8%)	(n=145) (36.8%)	(n=136) (34.4%)	Wald	p-value	Group differences [a]
Benefits	72.4%	69.8%	68.0%	79.3%	4.331	0.630	ns
Retired	1.3%	0.1%	2.9%	0.5%			
Employed	14.0%	16.4%	16.4%	9.6%			
Other	12.2%	13.7%	12.7%	10.6%			
Primary diagnosis							
Schizophrenia	26.8%	37.2%	30.8%	13.8%	1136.088	0.000*	
Other psychotic disorder [b]	24.6%	39.3%	16.9%	20.3%			
Mood disorder	12.4%	5.5%	21.6%	8.2%			
Anxiety disorder	7.1%	3.0%	3.5%	14.3%			
Developmental disorder	9.9%	2.6%	13.6%	12.0%			
SUD	1.5%	2.4%	0.0%	3.0%			
Other Axis 1 diagnosis [c]	3.0%	3.3%	2.4%	3.5%			
Personality disorder	14.7%	6.8%	11.3%	24.9%			
SUD	38.2%	34.3%	37.0%	42.9%	1.595	0.450	ns
Feeling unsafe (Safety Monitor)	52.6%	36.1%	54.5%	64.4%	14.649	0.001*	G<D,V

Table 4. *Continued*

	Full sample	Class 1: General Difficulties -class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N=395)	(n=114) (28.8%)	(n=145) (36.8%)	(n=136) (34.4%)	Wald	p-value	Group differences [a]
Expecting to be a victim in next 12 months (Safety Monitor) [d]	3.00	2.24	2.97	3.66	10.529	0.005*	G<V
Avoiding social participation [e]	1.27	1.24	1.14	1.43	3.006	0.220	ns
Stagnation in social participation [e]	1.35	1.10	1.19	1.73	18.165	0.000*	V>G,D
Social support (ISR) [f]	27.59	29.15	26.00	27.99	7.110	0.029*	G>D
Self-efficacy (MHCS) [g]	66.06	72.45	65.83	60.94	41.590	0.000*	G>D>V

Note: p value of Wald statistic, * $p < .05$

SUD = substance use disorder

[a] *General Difficulties* class, D: *Discriminated and Avoiding* class, V: *Victimized and Perpetrating* class, ns: no significant paired comparisons

[b] Other psychotic disorders are: brief psychotic disorder, delusional disorder, psychotic disorder due to a general medical condition, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, and substance-induced psychotic disorder

[c] Other Axis 1 diagnoses are: cognitive disorder, dissociative disorder, eating disorder, intermittent explosive disorder, pedophilia, alcohol-induced persisting amnestic disorder, impulse-control disorder, and somatization disorder

[d] Sum scores are presented (minimum = 0, maximum = 12)

[e] Item score is presented (minimum = 0, maximum = 3)

[f] Sum scores are presented (minimum = 12, maximum = 44)

[g] Sum scores are presented (minimum = 24, maximum = 96)

Table 5. Psychosocial functioning (HoNOS) and quality of life (MANSA)

	Full sample	Class 1: General Difficulties -class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N = 395)	(n = 114) (28.8%)	(n = 145) (36.8%)	(n = 136) (34.4%)	Wald	p value	Group differences a
Psychosocial functioning							
Aggression ^{b}	0.670	0.352	0.584	1.032	20.611	.000*	V>G,D
Self-harm	0.154	0.001	0.176	0.260	0.780	.680	ns
Substance use	0.791	0.462	0.770	1.098	12.188	.002*	G<D,V
Cognitive dysfunction	0.921	0.833	0.876	1.044	2.346	.310	ns
Physical disability	1.085	1.122	0.957	1.194	1.426	.490	ns
Hallucinations and delusions	0.783	0.908	0.710	0.756	1.604	.450	ns
Depression	1.124	0.765	1.140	1.409	17.765	.000*	G<D,V
Other symptoms	1.801	1.721	1.696	1.985	2.916	.230	ns
Personal relationships	1.490	1.214	1.308	1.922	20.540	.000*	V>G,D
Overall functioning	0.853	0.760	0.876	0.906	1.109	.570	ns
Residential problems	0.540	0.365	0.351	0.891	18.737	.000*	V>G,D
Occupational/recreational problems	0.737	0.501	0.654	1.024	12.035	.002*	V>G,D
Total psychosocial functioning ^{c}	10.812	8.895	9.963	13.335	29.185	.000*	V>G,D
Quality of life							
Life as a whole ^{b}	4.391	4.785	4.488	3.960	14.920	.001*	V<G,D
Job (or sheltered employment)	5.060	5.334	5.063	4.772	1.962	.370	ns

Table 5. *Continued*

	Full sample	Class 1: General Difficulties -class	Class 2: Discriminated and Avoiding class	Class 3: Victimized and Perpetrating class			
	(N = 395)	(n = 114) (28.8%)	(n = 145) (36.8%)	(n = 136) (34.4%)	Wald	p value	Group differences [a]
Unemployed/retired	4.126	4.233	4.619	3.610	5.609	.061	G>D
Financial situation	4.048	4.556	4.238	3.422	18.641	.000*	V<G,D
Number and quality of friendships	4.739	5.077	4.560	4.644	6.182	.045*	G>D,V
Leisure activities	4.545	5.028	4.671	4.003	20.012	.000*	V<G,D
Accommodation	4.939	5.566	5.043	4.303	25.528	.000*	G>D>V
Personal safety	5.154	5.437	5.391	4.664	20.944	.000*	V<G,D
People that you live with	5.283	5.581	5.487	4.831	6.498	.039*	V<G,D
Living alone	4.689	4.854	5.018	4.184	8.076	.018*	V<G,D
Sex life	3.942	4.177	3.891	3.811	2.261	.320	ns
Relationship with your family	4.763	5.521	4.677	4.217	22.491	.000*	G>D,V
Physical health	4.127	4.556	4.131	3.763	9.827	.007*	D>V
Mental health	3.932	4.441	3.885	3.555	14.665	.001*	G>D,V
Total quality of life [d]	4.501	4.927	4.572	4.069	47.556	.000*	G>D>V

Note: p value of Wald statistic, * $p < .05$

[a] G: General Difficulties class, D: Discriminated and Avoiding class, V: Victimized and Perpetrating class, ns: no significant paired comparisons

[b] mean item scores are presented for each item of the HoNOS and MANSA

[c] Sum scores are presented (minimum = 0, maximum = 31)

[d] Mean scores are presented (minimum = 1.75, maximum = 6.55)

In terms of the overall score on quality of life (MANSA), the "Victimized and Perpetrating class" scored the lowest, followed by the "Discriminated and Avoiding class" and "General Difficulties class". Significant differences also emerged in several specific domains of the MANSA. The "Victimized and Perpetrating class" had the lowest scores for all items, except for the following items: 'Having seen a friend in the last week', and 'Satisfaction with the number and quality of friendships'. On these latter items, the "Discriminated and Avoiding class" scored the lowest.

The three classes differed significantly in terms of self-efficacy and empowerment. Persons in the "Victimized and Perpetrating class" had the lowest scores for self-efficacy, followed by the "Discriminated and Avoiding class" and the "General Difficulties class".

Finally, individuals in the "Victimized and Perpetrating class" scored significantly higher on expecting to become a victim compared with the "General Difficulties class". With regard to feelings of unsafety, the three classes differed significantly; the "Victimized and Perpetrating class" had the most persons that felt unsafe (64.4%), followed by the "Discriminated and Avoiding class" (54.5%) and the "General Difficulties class" (36.1%).

Discussion

Principal findings

This study supports the existence of three distinct and meaningful patient profiles in relation to victimization, perpetration, discrimination, and social functioning, and provides information to help identify which patients might best benefit from what type of care. The group with the highest prevalence of victimization was the "Victimized and Perpetrating class" (34.4%). This class contained the lowest percentage of individuals with schizophrenia and had a relatively high percentage of individuals with a personality disorder. Furthermore, this class is characterized by problems in multiple domains, such as psychosocial functioning, self-efficacy, and quality of life. The class with moderate scores for experienced discrimination, victimization, and perpetration, the "Discriminated and Avoiding class" (36.4%), had the lowest scores on the subscales of social functioning ('interaction', 'recreation', 'pro-social'). More specifically, individuals in this class undertook the least pro-social activities and experienced the least social support from their environment. Moreover, this group included more individuals with depression, bipolar disorder, and developmental disorder. The "General Difficulties class" (28.8%) had the lowest scores for experienced discrimination, victimization, and perpetration, and was comparable with the general population with regard to victimization and feelings of unsafety [30]. In this class, more individuals had schizophrenia or other psychotic disorders than in the other two classes.

Strengths and limitations

A major strength of this study is that, to our knowledge, it is the first to examine whether classes are distinguishable in outpatients with severe mental illness with regard to experienced discrimination, victimization, and perpetration, and social inclusion. There is evidence that these concepts interact [23], and that these interactions differ within the large target group of outpatients with severe mental illness [13,14,46]. However, studies that formulated classes of outpatients with SMI examined heterogeneity only in relation to victimization and perpetration, or social recovery, but did not perform an LCA on all indicators [10]. Other studies that did perform LCA on victimization, included only adolescents [47]. Another strength of the present study is the detailed set of variables used to describe the classes, together with the relatively large sample size.

The following limitations should also be considered. First, there is a possibility of selection bias. For example, patients were excluded when they had insufficient understanding of the Dutch language, prolonged clinical admission (i.e., longer than the inclusion period), and florid psychosis or psychiatric crisis. Although we invited all patients in the participating teams and has a relatively long inclusion period to ensure representativeness, this might have led to a selection effect. We attempted to compensate for this with the 6-month inclusion period and by excluding as few patients as possible thereby keeping the sample as representative as possible. Due to privacy issues we could not examine whether patients who declined participation differed on all patient characteristics, however, the in the non-response analyses no differences were found. Furthermore, our sample was comparable with some characteristics in other studies done in persons with SMI. Participants in our sample scored 10.8 on psychosocial functioning, compared to a norm score of 11.4 [35], and 51.4% of our sample was diagnosed with schizophrenia or other psychotic disorder, compared to 64% and 67% respectively, in a large Dutch sample [48].

A second limitation is that, in the present analyses, only the current status of participants with regard to discrimination, victimization, perpetration, and participation were taken into consideration. It is known that outpatients with severe mental illness often switch between relapses and more stable periods in which there is room to regain social roles. Moreover, the overlap between victimization and perpetration may change over time [10]. Consequently, individuals may have switched classes over time, which leads to possibly varying scores on discrimination, victimization, perpetration, and social functioning.

Finally, since patients received financial compensation for their investment of time, this may have influenced the study results. The advantages/disadvantages of financial compensation continue to be discussed; it remains a controversial topic due to ethical issues, especially with marginalized groups and, in this case, with potentially complex/emotional interview topics [49,50]. Moreover, compensation might influence the accuracy of our study results, as some patients might participate only for the financial reward [49].

On the other hand, participants tend to agree with financial compensation, recognizing both their investment of time and the value of their participation [51].

Interpretation of findings

In the present study, the overall victimization rate was 46.8%, i.e., much higher than the overall perpetration rate of 17.5%. This is in line with previous studies that included outpatients with severe mental illness [2,5,6]. Our findings support the idea that persons with severe mental illness are more often victims than perpetrators of any type of crime. However, our results also indicate that, for some individuals, victimization and perpetration are interwoven. The "Victimized and Perpetrating class" showed perpetration rates ranging from 12.1% for property perpetration to 31.7% for personal perpetration, and victimization rates ranging from 36.4% for digital victimization to 50.1% for personal perpetration, indicating that, in this class, both victimization and perpetration rates are high compared to those in other studies on individuals with severe mental illness [2]. Simmons et al. [52] used the ecological model to explain why the accumulation or co-occurrence of victimization is problematic. A person has several layers of social context surrounding him/her (e.g., the individual, partner, family, and neighborhood) and when fear or victimization occurs in one or more layers, negative effects of this adverse event on the individual level (e.g., anxiety or depression) also accumulate. This is in line with the low rates of self-efficacy, quality of life, and psychosocial functioning, found in the "Victimized and Perpetrating class" in our study.

For the "Discriminated and Avoiding class" and the "General Difficulties class", the highest victimization rates were found in property victimization; this is similar to previous studies in persons with severe mental illness [2,5,6]. The "Victimized and Perpetrating class" had the highest overall rates for victimization and, more specifically, personal victimization (50.1%) (i.e., sexual harassment or assault, threats of violence, physical assault). These high rates of personal victimization were not found in previous studies, not even in more specific groups such as inpatients or patients with substance use disorder, in which the prevalence rates are expected to be higher [4]. Thus, it appears that the "Victimized and Perpetrating class" is a group of patients that are negatively characterized in two ways; individuals in this class have a higher chance of not only being a victim of a serious criminal incident, but also being a perpetrator and having significant problems in several life domains (as well as in self-confidence and quality of life).

The present study found a high percentage (17.5%) of poly-victimization in the "Victimized and Perpetrating class". To date, co-occurrence (or poly-victimization) has mainly been investigated in adolescents [8]. For adults with severe mental illness, one Dutch study found a prevalence rate of 9.9% in severe mental illness outpatients and 2.2% in the general population [2]. Although this rate seems similar, Kamperman et al. [2] defined a poly-victim as an individual that has experienced four or more incidents, irrespective of the type of victimization, i.e., a less strict definition than that used in the present study. According to their definition, 45.8% of the "Victimized and Perpetrating class" would be a poly-victim, and < 5% in the "Discriminated and Avoiding class" and "General Difficulties class". In the present study, the "Victimized and Perpetrating class" comprises patients are not only at high risk of being victimized but are also a victim in a large number of independent criminal incidents.

The "General Difficulties class", with the lowest prevalence rates in victimization and perpetration, had the highest percentage of persons with schizophrenia (48.4%), compared to the other two classes (36% and 18%, respectively). This is in contrast to the belief that, in persons with severe mental illness, a diagnosis of schizophrenia is mostly related to problems in certain life domains and, moreover, being violent and unpredictable [53]. Similar to our results, Gray et al. [54] found that, in secured mental health services, persons with schizophrenia were the least likely to commit a crime and those with personality disorder the most likely. In a study in which both victimization and perpetration were included in the analysis, they also found a lower victimization and perpetration rate in persons with schizophrenia compared to other diagnoses [55,56].

All these results suggest that, in persons with severe mental illness, other risk factors play a role in the development of criminal behavior. Some of these other risk factors are well established, e.g., homelessness or supported living, and substance use [4]. However, in the present study, we found only small differences in the living situation within the classes with high and low victimization. It should be noted that, in our sample, < 1% had no permanent housing. Registered substance use disorder showed no significant difference between the three classes. However, the HoNOS item 'problems with substance use' showed a significant difference between the "Victimized and Perpetrating class" and the "General Difficulties class", the former having more problems in this area; this indicates that, although the diagnosis of substance use disorder did not differ across the classes, mental health professionals assign more problems to substance abuse in this class.

Clinical implications

The elevated prevalence of victimization and perpetration among persons in the "Victimized and Perpetrating class", and the experienced discrimination in the "Discriminated and Avoiding class", which in together comprise > 70% of our sample, suggests that outpatients with severe mental illness need more targeted support to prevent (re-)victimization and perpetration while regaining valued social roles. Although improvement in social functioning is a central aim of outpatient teams, the results of this study suggest a specific need for additional support to address difficulties related to community living.

Also, although the “General Difficulties class” had the least victimization of the three classes and had relatively low scores on psychosocial functioning, this class still has problems finding paid employment (16.4% have a regular job). This class seems to hit a ‘glass ceiling’ when trying to achieve paid employment. Therefore, mental health professionals should consider using more supported employment interventions (e.g., individual placement and support) in this class [57].

The “Discriminated and Avoiding class” had the lowest scores for social functioning items and experienced the least social support. Moreover, they were the least satisfied with the number and quality of friendships. When professionals stimulate these patients to participate socially, the focus should be on reducing the experienced discrimination and stigmatization. One intervention shown to be effective in reducing self-stigma is Narrative Enhancement and Cognitive Therapy, which focus on restructuring negative self-beliefs and enhancing the ability to narrate their life story [58,59].

According to the mental health professional, the “Victimized and Perpetrating class” had the most conflicting personal relationships, of the three classes. Moreover, mental health professional s saw the most stagnation in social participation. This implies that, although they are socially active (as evidenced by their social functioning scores), they experience several difficulties in the process. Although professionals recognize problems in the social domain, there is room for improvement in outpatient mental health care. In practice, the focus of these teams tends to be on crisis management and less on rehabilitation [60], partly because of a fear of an increase in symptoms when addressing victimization [22].

To conclude, exposure to victimization related to social participation is an important factor in the lives of people with severe mental illness and encompasses more than psychological trauma alone. Therefore, an extensive form of trauma-sensitive and difficulty-sensitive care should be incorporated in outpatient mental health care [61], allowing room for taking (calculated) risks, as these are necessary in the social recovery process [62]. When addressing adverse incidents, calculated risks need to be acknowledged as part of the recovery process [25]. Therefore, particularly for the “Victimized and Perpetrating class”, mental health professionals should focus on preventing (re-)victimization in rehabilitation trajectories by addressing these experienced difficulties and turning them into calculated risks.

Future research

Latent growth analyses over an extended period of time are valuable; they allow to examine whether patients with severe mental illness switch classes over time, and whether scores on victimization and other indicators vary over time. This may provide additional tools to help mental health professionals to individualize care and upscale/downscale the focus on rehabilitation as required. Additionally, future studies on rehabilitation should include other measures related to social functioning, that are more in-depth measures on social activities and possible issues. On the SFS, we found low variability in our sample. Furthermore, scores for social functioning were almost as high as those found in the general population [63]. Although this is a validated and often used measure for social functioning, the SFS focuses more on (daily and social) activities and to a lesser extent on the social capital of the network. This study provides a first insight into the heterogeneity that exists in victimization and social functioning: for future research, it is recommended to include social network and support measures to gain more insight into the number and type of social relations that patients have.

General conclusion

This study provides further evidence for the high victimization rates in persons with severe mental illness, and it reveals three distinct subgroups that differ greatly in terms of discrimination, social participation, victimization, and perpetration. The results offer new insights for mental health professionals of outpatient teams, and support the need for a more individualized approach in rehabilitation trajectories for patients with severe mental illness. The need to acknowledge and incorporate experiences of perceived stigma, discrimination, and victimization in the treatment and rehabilitation plan is advocated in order to increase the number of successful rehabilitation processes and reduce victimization rates.

Appendix

S1 Table. Scores of the three classes on discrimination, victimization, perpetration, and social functioning

	Full sample	Class 1 (General Difficulties class)	Class 2 (Discriminated and Avoiding class)	Class 3 (Victimized and Perpetrating class)
	(*N* = 395)	***n* = 114 (28.8%)**	***n* = 145 (36.8%)**	***n* = 136 (34.4%)**
Experienced discrimination (mean)	0.420	0.042	0.312	0.853
Victimization incidents				
0	53.2%	75.2%	60.4%	27.0%
1	24.3%	19.8%	26.5%	25.7%
2	11.6%	4.2%	9.5%	20.2%
3	5.8%	0.7%	2.8%	13.4%
4	3.3%	0.1%	0.8%	8.7%
5	0.8%	0.0%	0.1%	2.1%
6	0.8%	0.0%	0.0%	2.2%
7	0.3%	0.0%	0.0%	0.7%
Mean	0.884	0.309	0.573	1.697
Perpetration incidents				
0	82.5%	97.4%	88.7%	63.5%
1	11.9%	2.5%	9.8%	22.0%
2	4.1%	0.1%	1.4%	10.3%
3	1.0%	0.0%	0.1%	2.8%
6	0.3%	0.0%	0.0%	0.7%
7	0.3%	0.0%	0.0%	0.7%
Mean	0.263	0.027	0.129	0.605
Social functioning (mean)	748.551	760.496	739.404	748.338

S2 Table. Scores of the three classes on poly-victimization, both definitions

	Full sample	**Class 1 (General Difficulties class)**	**Class 2 (Discriminated and Avoiding class)**	**Class 3 (Victimized and Perpetrating class)**
	(*N* = 395)	***n* = 114 (28.8%)**	***n* = 145 (36.8%)**	***n* = 136 (34.4%)**
Poly-victimization (definition A)	17.7%	4.0%	2.3%	45.8%
Poly-victimization (definition B)	5.1%	0.5%	0.0%	17.5%

Definition A: 4 or more incidents in one year
Definition B: 4 or more separate incidents in one year

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3

Development of an intervention aimed at increasing awareness and acknowledgement of victimization and its consequences among people with severe mental illness

Published as:
Albers WMM, Nijssen YAM, Roeg DPK, Bongers IMB, van Weeghel J. Development of an Intervention Aimed at Increasing Awareness and Acknowledgement of Victimisation and Its Consequences Among People with Severe Mental Illness.

Community Ment Health J. 2021;57(7):1387.

Abstract

Individuals with severe mental illness have a significant risk of (anticipated) discrimination and (criminal) victimization, which is not structurally and systematically addressed by mental health practitioners. The aim of this study was to develop and pilot an intervention which supports professionals to address victimization and its consequences, in order to reinforce safe social participation and improve recovery. Following the rehabilitation and positive risk management literature, in addition to current practice, intervention components were developed in two focus groups and four subsequent expert meetings. The intervention was piloted in two outpatient teams before being finalized. The Victoria intervention includes positive risk management, focusing on clients' narratives and strengths, and awareness of unsafe (home) environments: it comprises four steps: exploring issues with social participation, analyzing victimization experiences, clarifying the context of these experiences, and determining future steps, including victimization-sensitive rehabilitation planning and optional trauma treatment. Future research should further test this intervention.

Keywords
staff training, rehabilitation, victimization, social participation, severe mental illness, discrimination

Introduction

The shift in mental healthcare from hospital-based toward community-based treatment has placed a stronger focus on the rehabilitation and recovery of individuals with severe mental illness (SMI) [1,2]. Despite several positive developments that brought forth a greater focus on an inclusive society for people with SMI, including goal attainment [3] and employment [4], social participation remains much lower in people with SMI than in the general population. Only 10-20% of such individuals hold down a paid job and around 75-85% have neither paid nor voluntary work [5,6]. Furthermore, the social networks of people with SMI tend to be smaller and less satisfactory than those of the population as a whole [7-10].

Along with the rise of community mental health care came a growing emphasis on the risks that individuals with SMI have to deal with in participating in that community, such as discrimination and victimization [11]. Discrimination is the behavioral aspect of the public stigma attached to mental illness and is defined as being treated in a negative way because of this mental illness [12]. Victimization is the process of being victimized, and this may be of a violent crime (sexual assault, physical assault) or a non-violent crime such as a property crime (theft, burglary), a digital crime (identity fraud or hacking), or other types of (emotional) abuse or social exploitation [13,14]. In this study, it always involves recent victimization. Many clients experience discrimination because of their psychiatric diagnosis, even on a daily basis [15,16]. Criminal victimization is also highly prevalent in individuals with SMI; they are considerably more likely to be a victim of crime than others in the community [13,17-21]. A large Dutch study identified that Dutch outpatients had six times more incidents than the rest of the population in the previous year [18]. For personal crimes (e.g., sexual harassment/assault, violence, physical assault), the rate is almost 14 times higher than the rate for the rest of the population [18]. Moreover, the majority of perpetrators are familiar to the victim (e.g., a family member, roommate, or neighbor) [22]. Victimization, including (anticipated) discrimination, may lead to a vicious cycle of stressful events that are associated with an increase in psychiatric symptoms, substance abuse, an elevated chance of offending, social isolation, a loss of confidence, and even a lower quality of life [14,16,23-25].

Several studies have also negatively linked victimization and discrimination to recovery [14] and, more specifically, to social participation [26,27]. The 'why-try' effect, a process of demoralization among service users, was defined as the effect of perceived stigma and self-stigma and subsequent decreased self-esteem and self-efficacy [28]. This leads them to become discouraged or demoralized about pursuing actions that could advance their recovery process [28]. In addition, clients who do not engage in meaningful daily activities tend to experience more victimization than clients who do [26]. The relationship between victimization, including (anticipated) discrimination, and social participation tends to be a reciprocal one. Victims of violence tend to acquire problems with maintaining meaningful relationships [29]. Moreover, experiences of being rejected can instigate anticipated stigmatization, and can thus discourage clients from pursuing their rehabilitation goals and wishes [28], or even lead them to refraining and retracting from participation in community life [30].

In outpatient mental health care, professionals have the statutory duty to work with other organizations, partners, and clients' social environment to identify and address victimization [31]. However, many victimization incidents remain un-identified and the impact on participation is hardly addressed [14]. One of the reasons for this is that professionals have almost no tools to systematically address the impact of recent victimization related to participation, besides interventions for childhood and/or severe trauma [19,32]. Consequently, interventions on recent victimization experiences are only minimally integrated into treatment and rehabilitation plans [33,34]. Paradoxically, addressing recent victimization is often even seen as increasing the risk of a relapse and therefore preferably evaded [32]. However, research has shown that the opposite is true; discussing the impact of victimization experiences can benefit a person's recovery process [35-37], and reduce re-victimization [38].

Given the lack of interventions dealing with the impact of victimization related to social participation, this study aims to develop an intervention and an accompanying training program to support professionals to initiate the conversation on victimization with clients to both address its impact and prevent re-victimization, in order to reinforce safe social participation, and to improve recovery. In the definition of victimization, we include both (criminal) victimization and (anticipated) discrimination.

Literature review

A review of the extant literature provided several studies on the prevalence of victimization and discrimination [16,21,22,39-41], or on their risk factors, such as homelessness or substance abuse [42-44]. Studies that described interventions mainly focused on preventing victimization, for instance, teaching clients to acquire street smarts skills [45,46]. Studies on the effectiveness of those interventions, however, have not been conducted. Research on anti-stigma interventions is far more extensive and several effective tools exist, such as Narrative Enhancement and Cognitive Therapy [47,48]. Although these interventions provide promising results, they cover only a part of the risks that individuals have to deal with in community life. Moreover, we found no effective interventions on detecting victimization and its impeding effects on social participation.

As a possible solution to one of the responses to victimization or discrimination, i.e., demoralization among service users, in several studies it is argued that focusing on empowerment (positive) rather than reducing self-stigma (negative) is more effective in mental health interventions that support recovery [49,50]. In addition, understanding why a client is demoralized by their previous experiences may remove the barrier to inclusion [37,51].

Being recognized as a human being and feeling connected is a fundamental human need; it is helpful to address this in a more structural and methodical way in a mental health care context, as this connectedness or empathy can facilitate productive therapeutic outcomes [52,53]. In addition, empathy establishes the client's 'sense of coherence', which is the ability for people to understand what happens to them and to find meaning in this, i.e., the way individuals view their life; this has a positive influence on their health and builds resilience [54,55]. More specifically, being connected is achieved by acknowledging the pain and struggle, and contributes to recovery [56].

Next, we searched for intervention strategies concerning these mechanisms. We elaborated on the concept of "dignity of risk", first articulated by the consumer movement [57], which states that every individual has the right to take reasonable risks to progress in life. This is no less true for individuals with SMI. Risk in mental health care was often used in terms of risk management or reduction, in which the professional assessed whether the client posed a risk to their local community [58]. Indeed, overprotecting and discouraging clients from taking necessary risks may harm their self-esteem and decrease hope and future perspectives. Building upon this positive perspective, Burns-Lynch et al. [35] developed a guide in which the dignity of risk and the client's personal choices are promoted and elaborated toward a concept methodology of professional work, including shared decision-making, the aim of which is for individuals with SMI to feel community inclusion. They stated: "There is an inherent risk in almost everything we do in our lives. This should not exclude us from participating, but rather ensure that we properly plan to mitigate the harm that can be associated with the various domains and life activities" [35 p.17]. In this approach, community integration is the road to recovery, *including* promoting the dignity of risk. In each life domain, the client's goal is formulated through shared decision-making, including the required skills, barriers, and supports. Subsequently, the risks are assessed per domain to determine the appropriate action. This approach, often labelled 'positive risk management', has also been promoted by the UK government [59]. It not only promotes a systematic risk assessment, but also propagates a focus on the client's strengths. To comprehensively implement this positive risk approach, mental health professionals require skills to assess the client's risks, strengths, and autonomy [59].

In sum, professionals should probe for the reasons clients hesitate to pursue rehabilitation goals, to identify the possible impact of victimization experiences. Addressing victimization experiences is thought to increase the client's feelings of acknowledgement, improve the working alliance, and create better coping skills for future vulnerable situations (i.e., tertiary prevention [60]).

Methods

Design and procedure

A vital aspect of this development process was its fit with the existing rehabilitation methodologies used by the participating outpatient teams: the Boston University Approach to Psychiatric Rehabilitation (BPR). This person-centered approach was developed to support clients in housing, employment, education, and social contact [1]. The victimization-informed intervention was developed through an iterative process (Fig. 1), using input from the literature review, pilot teams, focus groups, and expert meetings with a core development group and other experts in the field. The core development group consisted of professionals from 'Rehabilitation '92' (considered to be the leading training facility for the BPR in the Netherlands), researchers, and mental health professionals including experts by experience, and mental health nurses from Flexible Assertive Community Treatment (F-ACT) teams. We did not use formal consensus development methods, such as the Delphi method, but structured discussion was used to reach consensus on the desired content of the intervention [61]. The core development group structured information gathered in each development phase and incorporated this into the intervention. No client data were collected during the intervention's development, so medical ethical approval was not needed. In addition, there were no known conflicts of interest to report.

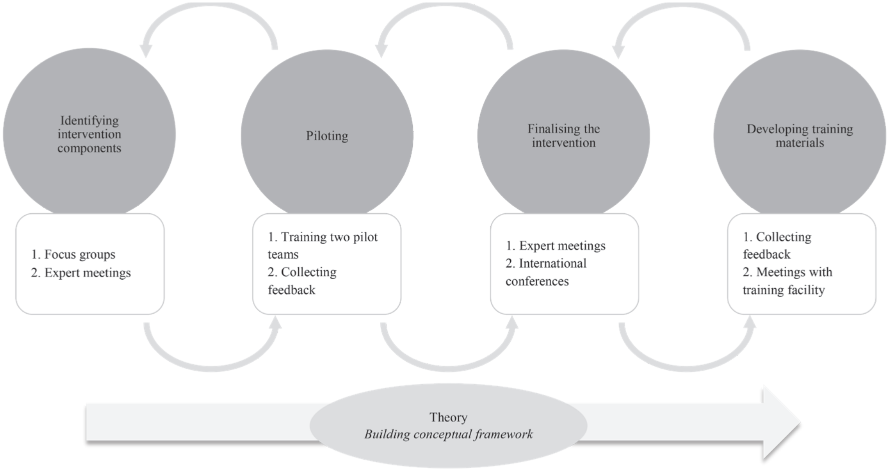

Figure 1. Development process of the intervention

Setting

F-ACT teams from two mental healthcare organizations in the Netherlands (Parnassia (formerly Dijk & Duin) and GGzE) and Rehabilitation '92 collaborated in the intervention's development. F-ACT is the leading community mental healthcare program for people with SMI in the Netherlands [62]. Individuals with SMI have a diagnosis according to the DSM-IV, such as schizophrenia or other psychotic disorders, major depression, or personality disorder [63]. SMI is also defined by illness duration and impact the diagnosis has on one or more major life activities. F-ACT teams are multidisciplinary and comprise mental health professionals such as psychiatrists, psychologists, employment specialists, psychiatric nurses, and experts by experience. One intended benefit of F-ACT is that clients receive care in both periods of stability, where there is a greater focus on rehabilitation, and periods in which they are more at risk of relapse [62]. Several team members from each site assisted in developing the intervention, and two teams participated in the pilot. Both pilot teams were certified F-ACT teams according to the official Dutch fidelity guidelines [64].

Development process

Phase 1: Identifying intervention components

Two focus groups were held at the end of 2013 to generate ideas about the content, conditions, and scope of the intervention. Each focus group consisted of around 12 people with varying professional expertise: (specialist) mental health nurses, psychiatrists, psychologists, experts by experience, researchers, and rehabilitation experts. The topics addressed in the two focus groups were: 1) identifying obstacles to social participation related to victimization and 2) exploring support to address these negative experiences. These topics were addressed from the perspectives of the client, their social network, and a professional caregiver. Cases brought in by the professionals were used to lead the discussion.

Two researchers then translated the results of the two focus groups into the first draft of the intervention. Further elaboration was obtained using a series of four expert meetings with the core development group.

Phase 2: Piloting the intervention

The first version of the victimization-informed intervention was piloted in two F-ACT teams at the end of 2014. One team from each site was purposively selected; this selection was based on the entire team's motivation to contribute to developing a new intervention and their affinity with the topic [65], basic knowledge of rehabilitation methods, and having at least one rehabilitation expert and one expert by experience on the team. All team members involved in the pilot teams received training in the intervention. The main goals of the pilot were to identify the barriers to intervention delivery, to examine the feasibility and acceptability of the intervention components, and to monitor the quality and quantity of intervention delivery. We asked the team members to apply the intervention on indication, with the following instruction; explore victimization in clients within your caseload that have problems in participation. During and after the six months pilot period, all team member were interviewed individually via phone (Table 1), and the whole team was consulted to share their experiences of the intervention with the researchers once during a face-to-face meeting. These qualitative data will then be integrated into the intervention.

Table 1. Topics of consultations during piloting phase

Were you able to use the intervention (or elements thereof) in your daily job routine? Yes:
With whom, and why that client specifically?
What was the context of the conversation?
How? What was the reason for the conversation? Was there a goal?
Which intervention steps did you take?
What was difficult?
Was it useful? Did it help you?
Are there necessary adjustments to the intervention or conditions?
What was the client's reaction?
Were you able to use the intervention (or elements thereof) in your daily job routine? No:
No suitable clients; clients did not respond well to intervention
Unsuitable context (of client)
Intervention protocol insufficient or should be adjusted
Insufficient preconditions

Phase 3: Finalizing the intervention

Ten expert meetings were organized to translate the findings from the feasibility pilot into concrete adaptations in order to finalize the intervention. The expert meetings varied in their composition but mainly included professionals from the core development group. Additionally, workshops were held at two international conferences: the 2015 European Network of Mental Health Service Evaluation International Conference and the 2015 European Conference on Assertive Outreach [66,67]. Feedback from workshop participants about the content and form of the intervention was incorporated into it.

The final intervention is described using the template for intervention description and replication by Hoffmann et al. [68]. This template is a 12-item checklist developed as an extension of the CONSORT and SPIRIT statements to provide further guidance for authors regarding the key information to include in trial reports (including name, rationale, materials, procedures, mode of delivery, and infrastructure).

Phase 4: Training and supervision

The core development group generated the training materials, incorporating feedback and insights collected during the previous phases.

Results

Results from the focus groups, expert meetings, and pilot

This section will present the results per phase of intervention development and will end with a description of the final intervention, entitled the ‘Victoria’ intervention, which refers to victory and victimization.

Phase 1: Identifying intervention components

First, in the focus groups, 21 barriers to social participation were identified and grouped by source (i.e., clients, clients’ social network, mental health professionals). The aforementioned barriers included the lack of belief in the client’s abilities (i.e., by their social network and professionals) and clients’ experiences with unsafe living environments (see Table 2).

Second, participants were asked to develop solutions. One important suggestion was that the intervention should be integrated into existing methods and daily practice. Furthermore, participants suggested that it should aim to identify and evaluate risks in social experiences with a focus on the client’s strengths instead of a focus on signals that precede a relapse. Finally, connecting to the client’s narrative was an underlined intervention component.

In the subsequent expert meetings, participants underlined a focus on both the awareness and dignity of risks, staying connected to the client’s narrative, and targeting the client’s strengths. Furthermore, in terms of practicality, they determined that the intervention should specifically target victimization experiences, be easy to execute, and include a limited number of ingredients. The experts had some difficulties incorporating the role of relatives into the intervention, aside from focusing on the social network’s role in rehabilitation, and decided to stick to the original aim: develop an easy-to-use intervention that incorporates existing methods by focusing on the interaction with the client.

Table 2. Intervention components based on focus groups

	Perspective		
	Client	**Client’s network**	**Mental health professional**
Barriers to social participation	• Lack of self-esteem and confidence • Fear of relapse • Fear of negative reactions from society • Negative experiences with participation or negative learning experiences • Lack of finances or other facilities • Cognitive impairments • Positive/negative symptoms • Relationship with professional	• Lack of belief in client’s resilience • Keeping client from rehabilitation • Lack of a safe home environment • Lack of support from relatives	• Lack of belief in client’s resilience • Client is not ready for a rehabilitation trajectory • Professional wants ‘too much, too soon’ • Not connected to the client’s narrative • Treatment plan is not specific enough in terms of responsibilities • Lack of communication with other organizations • Focus on crisis prevention • Too few supervision meetings about rehabilitation and recovery • Lack of knowledge on rehabilitation methods • Lack of (knowledge of) positive risk management
Suggested intervention ingredients	• Reduce professional distance • Stop filling out the client’s goals and wishes and focus on the client’s narrative • Believe in the client’s recovery • Increase usage of experts by experience • Put the client in the lead • Focus on the client’s strengths instead of their weaknesses • Incorporate a systemic approach • Support system for relatives, focus on perspective of support system • Integrate the intervention into existing methods • Identify and evaluate risks (‘dignity of risk’)		

Phase 2: Piloting the intervention

Overall, the pilot teams were able to use the intervention on a regular basis with several clients in their caseload, but they found it difficult to switch from a problem-focused attitude to development-oriented conversations. They had problems starting the Victoria conversation, especially with clients who initially had no obvious victimization experiences (e.g., violent assault is often more obvious than discrimination within their family). Furthermore, several mental health professionals were hesitant to use the intervention with clients who suffered from psychotic symptoms and severe substance use because of the client's distorted sense of reality. Mental health professionals also experienced difficulties with the intervention's division into two target groups: the group with a high risk of relapse over several life domains and the more stable group. Since clients can switch from one group to the other, it is difficult to determine the starting point of the intervention.

The professionals confirmed that using the intervention led to new insights about their clients, and it helped them better understand why a client had problems with participation. Additionally, it helped the professionals adopt an active listening strategy instead of providing immediate solutions. Interestingly, several experts by experience explained that they had already had these types of conversations with some clients. Finally, the professionals concluded that to successfully implement this intervention, it should be a structural topic in team meetings.

Phase 3: Finalizing the intervention

First, indications for the intervention were clarified in the expert meetings, as the pilot team members appeared to have difficulty in recognizing the signals that justified beginning the conversation. Second, the intervention targets the entire F-ACT caseload, as problems in social participation (either avoidance or stagnation) are the indication for starting it. Instead of only focusing on clients that have a higher chance of relapse over several life domains, all clients need support in social participation. In this way, Victoria was defined as a preamble or restart intervention for rehabilitation methods. Third, the content of the intervention was converted into delineated steps with a more clearly defined start and finish. This also adds to the better determination of the intervention's starting indication. There was a need for clear options after finishing the initial conversation, as not all problems relating to social participation are due to victimization experiences. This was incorporated into the last step. Finally, participating in international conferences supported the notions that mental health professionals often underestimate the prevalence of victimization, and that there should be a focus on the role of the social network in tackling victimization as a barrier for participation. This is incorporated in the 'clarifying context' step.

Phase 4: Training and supervision

Basic training in a rehabilitation methodology is fundamental, since experiencing difficulties in rehabilitation trajectories is a reason to start the Victoria intervention, with the intention of exploring whether victimization is blocking participation and getting back on track to (re)start rehabilitation.

Intervention training includes three half-day sessions provided by two trainers, one of whom is an expert by experience (as suggested in the expert meetings). These sessions focus on explaining the background of the intervention, including some theory, and explaining the four steps. To ensure the comprehensive implementation of the Victoria intervention, pilot teams suggested incorporating it into team meetings. As such, the first training session and supervision meeting includes a team brainstorm about ways to secure the intervention in the daily job routine on individual and team levels. The second and third training sessions include practicing in small groups by using role-play in which real-life cases are used and discussed; several fictitious cases are available. To ensure that professionals use the intervention in practice, supervision meetings with a Victoria trainer every 6-8 weeks form part of the training.

To assure fidelity, it is important that training sessions be similar across teams. Therefore, concrete materials were developed for train-the-trainer education, including a short educational film showing a good example of a Victoria conversation with a client. The film includes an expert by experience in conversation with a Victoria trainer. Other training materials are the manual and a shorter handout in two sizes: one to take along and a poster to display in the office.

Description of the Victoria intervention

Case vignette

To better understand the procedure of the Victoria intervention, a sample case is given below. This is based on cases brought in by mental health professionals during the development phases.

> *Tom is a 33-year-old man with a long history of mental healthcare and drug abuse. He lives with his mother in a small apartment. She cooks and takes care of the household. Tom has difficulty getting up in the morning and has no structured daytime activities. Lately, he hardly gets out of the house at all. His opinion is that by staying in the house, he keeps out of trouble. In one of the appointments with the case manager, the case manager explores why Tom keeps having issues with getting out. After a while, Tom admits that he was harassed by one of his former friends, who wanted money, which Tom did not have. Tom managed to get away, but after this incident, he lacked the confidence to go out more.*

Step 1: Exploring social participation

The *Exploring* step of the Victoria intervention (presented in Fig. 2) incorporates the elements and skills taught in the 'goal attainment module' of BPR and involves the evaluation of activity and satisfaction in the following life domains: housing, social contacts, education, and work. These domains are part of the rehabilitation methods used (the BPR in the pilot teams) [62]. With the client, the mental health professional determines whether the client is avoiding activities or whether the desired progress on these domains is stagnating. Specific to Victoria is the exploration of the possible role of recent victimization experiences in this. When problems regarding social participation are not linked to victimization (e.g., not having the right education for a desired job), the professional may (re)start a rehabilitation action plan with the client.

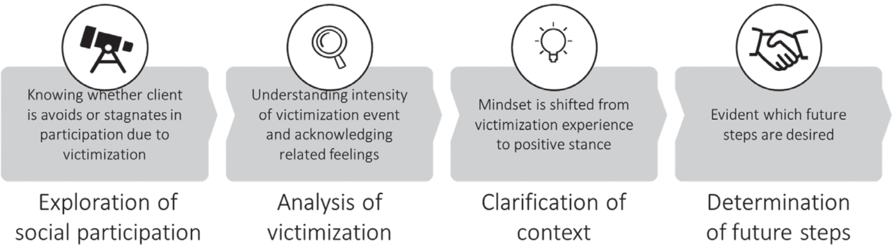

Figure 2. The four steps and the goals of the Victoria intervention

Step 2: Analyzing victimization experiences

While recent victimization appeared to play a hindering role in participation during step 1, the second step is *Analyzing victimization experiences* by addressing who, what, where, and when. The professional uses a client-centered approach [69] to effectively understand the intensity of and feelings related to this specific experience. In line with conversation techniques standard across mental health practice, or in BPR training, it is crucial that the professional uses an active listening strategy to support the client in elaborating on his/her victimization experience. Adding to these conversation techniques is a narrative approach in which the professional acknowledges the pain and struggle of the client's victimization experience (Rogers, Anthony, Lyass, & Penk, 2006). The overall goal in this step is to get a full picture of the event, to recognize and acknowledge feelings related to it, and to understand why it made the client stagnate in participating in, for example, paid or voluntary work, and daily or leisure activities.

Step 3: Clarifying the context of victimization experiences

The third step entails *Clarifying the context* of the victimization experiences and incorporates elements from the concept of the dignity of risk [57] and the positive risk approach [35]. The professional works with the client to examine the motive for engaging in the situation in which the victimization occurred. If the underlying desire or wish is clear, the client explains to the professional how they would have wanted the situation to go and what they had hoped to achieve by engaging in this situation. Again, it is critical that the professional use an active listening strategy, as the client's story and perceptions are crucial to fully understanding their reasoning and wishes (following the client-centered and narrative approach). This step intends to shift the mind-set from the victimization experience back to a more positive stance and change it into a learning experience. Application of the Victoria intervention is personalized, as one client may need and want several conversations and another may be satisfied with one or two, so several future steps are plausible.

Step 4: Determining future steps

The fourth and final step of the intervention is *Determining future steps* based on the results of steps 2 and 3. If both the client and the professional agree that the discussed experience is indeed an important obstacle to social participation (i.e., they become more aware of the barriers and the client feels acknowledged), then the next step is to (re)start the BPR rehabilitation action plan to work on the client's original rehabilitation goals and wishes from before the victimization experience, working to conform the principle of dignity of risk, and the positive risk approach, incorporating a risk management plan in order to prevent re-victimization. If the victimization experience was very intense, the professional should use the 'Trauma Screening Questionnaire' (TSQ) to investigate whether trauma-focused treatment is needed [70]. The ten items of the TSQ are answered 'yes' or 'no'; if six or more items are answered 'yes', trauma treatment may be beneficial and is advised in the Victoria intervention. When the victimization is still going on, mental health professionals would first discuss signs of victimization with the client, and in consultation with the client, the professional can consult family or friends. Following Dutch law and regulations, mental health professionals have the legal duty to report domestic violence and child abuse, violence and other crimes within mental health care organizations, and victimization in other settings when there is serious damage or danger for the client or others to expect [31,71,72].

Mode of delivery and infrastructure

The intervention is intended for individuals with SMI that experience problems with social participation; it was developed in such a way that it can be used by every professional in community mental health teams. In practice, it is largely used by professionals with their own caseloads (e.g., psychiatric nurses), but experts by experience can also use it due to their narrative working practice.

The Victoria intervention was developed to be used during regular meetings with clients, at the client's home or at the outpatient team's location. It is able to be integrated into regular work processes, and familiar conversational techniques are used to carry out the steps. Preferably, those steps are integrated into regular sessions where other issues are also discussed, rather than in separate appointments to solely discuss victimization experiences. It should be noted that the first step, exploring social participation, should be repeated regularly as part of standard rehabilitation. As clients' situations change over time, so do difficulties with social participation. Furthermore, it is advised that the professional have an agenda for these appointments and not be swayed by issues of the day.

Discussion

This paper outlines the development of a victimization-informed intervention that aims to expand the awareness and acknowledgement of victimization experiences and provide concrete professional tools in working with such experiences. The intervention aims, in this way, to encourage future safe social participation of people with SMI.

As a result of the feedback from the pilot group the victimization-informed intervention is positioned as a preamble intervention used as an add-on to existing rehabilitation methods. It builds on the phase in which the personal goals are defined in that it identifies victimization as a reason behind why people may stagnate in their goal attainment and thus participation. It is used as a precursor to identify if other trajectories or interventions on victimization are required, including trauma-focused treatment or additional Victoria conversations. One could also think of follow-up interventions which enhance participation that are focused on social support [73], anti-stigma interventions [74,75], or supported employment [76]. If the family has an impeding effect on the autonomy and participation of the client, family interventions may be required [77]. Moreover, with the recent developments in interventions such as Resource Group Assertive Community Treatment or resource groups [78], further development should focus on integrating the intervention in those methods, as we know that the social network has a great influence on both victimization and rehabilitation.

Our Victoria intervention was inspired by the concept of dignity of risk [57] and positive risk management [35], which have both recently attracted attention. A recent scoping review on recovery shows that it is important to maintain a balance between taking risks and safety in recovery processes, while still empowering clients [79]. Difficulties are inherent within a recovery process and should therefore be incorporated in recovery-oriented mental health services [56]. As Sweeney et al. [80] argued, this involves a shift from professionals thinking 'what is wrong with you?' to 'what has happened to you?', or move away from 'managing risk' to 'promoting safety and opportunity' [81]. A recent article of Jones [82] adds to this notion by suggesting a more positive stance towards risk. Moreover, risk and recovery go hand-in-hand. Slade et al. [83, p.52] agree and argue that: "the largest contribution by mental health services to supporting recovery may come from enabling the empowerment of patients to experience the full entitlements of citizenship".

Adopting victimization-informed care involves a shift in professionals' attitudes from being more symptom focused toward a more narrative-type approach that increases the awareness of and attention to victimization and may present several implementation challenges. First, professionals in mental health community settings often have to deal with large caseloads (in ACT and F-ACT teams: ten staff members for 100 to 200 clients) in which psychiatric crises, violence, nuisance, or urgent housing issues often draw attention away from rehabilitation needs. To overcome this potential barrier, we developed the Victoria supervision meetings as part of the training to support these professionals in overcoming this potential pitfall. Furthermore, the intervention's small and simple nature and its use as a preface to rehabilitation methods should contribute to its easy and frequent usage in daily practice. Professionals do not need to acquire an entire new skill set, as the conversation techniques in the intervention are standard practice in their education [84]. Second, the Victoria intervention requires a new perspective: a delicate balance between client safety and letting them take risks as part of their recovery process; embracing this paradigm will take time. Peer workers may have a pivotal role in this, as they understand the perspectives of both the professional and the client [85].

Strengths and limitations

To the best of our knowledge, this study is the first to describe an intervention that addresses victimization and discrimination experiences, which are hardly addressed but highly prevalent in clients with SMI on an almost daily basis, and form large barriers in their recovery. In contrast to current practice, this intervention aims to 1) address the experience in order to enhance acknowledgement, as well as 2) stimulate healthy and safe social participation. In this way, the intervention aims at enhancing current rehabilitation practices and recovery-focused working. Another strength is having used the extensive development period of two years, which allows for the intervention to be based on a range of findings, including information from several expert meetings, pilot testing, and focus groups. Its other strengths include the involvement of a range of stakeholders throughout the development process (professionals, rehabilitation experts, researchers, managers, clients, etc.) and the usage of conversation techniques that are standard practice in education which allow for an easier integration into daily practice.

Our study also has certain limitations that should be acknowledged. First, even though two years is enough for the development of an intervention, it is less generous for the testing of a solid implementation strategy. This study led to a training protocol, including three training sessions and regular supervision meetings with skilled trainers, and intervention tools to be used in daily practice. The next step would be to get experience in implementation, including further (graphical) development of the materials, creating awareness of the need for the intervention, and a sense of shared responsibility in mental health professionals and management to recognize and address victimization.

Second, during the piloting stage we did not include any additional quantitative data collection, which could have been informative about how many and which type of clients received the intervention. Finally, a fidelity instrument would be relevant to stimulate accurate use of the intervention.

General conclusion

Developing the Victoria intervention is a first step in addressing the victimization experiences that hamper many people with serious mental health problems in their social participation and general wellbeing. This intervention incorporates the recognition and acknowledgement of the victimization experiences that individuals with SMI face in their recovery process and provides both professionals with concrete tools to work on victimization and clients with new perspectives on rehabilitation. Next steps will be the evaluation of the effects of this intervention on social participation and victimization in a first (pragmatic) cluster randomized controlled trial, and the implementation process will be examined in a process evaluation.

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4

Effectiveness of an intervention for managing victimization risks related to societal participation for persons with severe mental illness

A cluster RCT study protocol

Published as:
Albers WMM, Roeg DPK, Nijssen Y, Bongers IMB, van Weeghel J. Effectiveness of an intervention for managing victimization risks related to societal participation for persons with severe mental illness: a cluster RCT study protocol.

BMC Psychiatry. 2018;18(1):247.

Abstract

Background
People with severe mental illness (SMI) are more likely to experience criminal victimization than other community members. In addition, (self-) stigma and perceived discrimination are highly prevalent in this group. These adversities in the social context often have major adverse effects on the rehabilitation and recovery of these persons. Current practice, however, lacks instruments to address these issues. As a reaction, the Victoria intervention was developed and pilot-tested with client representatives, professionals, trainers and researchers. The Victoria intervention is a method for community mental health care workers to expand their awareness of this topic and support them in assessing victimization and incorporate appropriate services, including trauma screening and rehabilitation services, in their health care planning. For clients, the Victoria intervention aims to increase their awareness, active management of possible victimization risks and promote safe social participation. As a new intervention, little is known about its use in real practice and its effects on client outcomes.

Methods/design
To determine the feasibility and effectiveness of this intervention, a process evaluation and a first cluster randomized controlled trial (RCT) will be carried out. Outpatients from eight Flexible Assertive Community Treatment (FACT) teams from two mental health care (MHC) organizations in the Netherlands are included in the study. Teams in the intervention group will receive three half-day training sessions, and bi-monthly supervision meetings for 18 months. Teams in the control group provide care as usual. For the process evaluation, a multimethod design is used. To assess effects on client outcomes, clients will be interviewed about their experiences on victimization and societal participation using validated questionnaires at baseline, and after 9 and 18 months.

Discussion
This study is the first to evaluate an intervention aiming at recognition of victimization, (self-) stigma and perceived discrimination, and targeting outpatients' insights into possible risks and coping skills to tackle these risks to enhance safe societal participation. Results of this study may validate the Victoria intervention as a practice to better manage risk for adversities related to societal participation.

Trial registration
Dutch Trial Register (NTR): 5585, date of registration: 11-01-2016

Keywords
Victimization, rehabilitation, recovery, societal participation, severe mental illness, stigma, risk management

Background

In most western countries, deinstitutionalization has led to an increase of community-based care with a focus on promoting the recovery and societal integration of people with severe mental illness (SMI) [1]. To achieve successful integration into community life, psychiatric rehabilitation methods were developed in order to support people with SMI to regain a meaningful life and valued social roles [2,3]. Within the field of psychiatric rehabilitation, several evidence-based practices can be identified. The Boston Approach to Psychiatric Rehabilitation (BPR) has proven to be effective in promoting new perspectives, role functioning, and life satisfaction [4,5]. Another evidence-based rehabilitation intervention is the Individual Placement and Support (IPS) model of supported employment [6]. Employment specialists successfully support clients to search for and get a job, and also coach clients about working situations in order to maintain employment.

There are still substantial challenges to work on in community-based care, especially concerning supporting clients in their social and community participation. A lack of support in these areas may lead to unemployment, poverty, social isolation and even imprisonment [7]. Studies have also shown that these negative consequences may lead to an increase of victimization rates [8-10]. Not only are people with SMI more likely to experience victimization than other community members, in contrast to popular public belief, they are also more likely to become a victim of a crime rather than being the perpetrator [11-15]. Prevalence rates of violent victimization among persons with SMI range between 7% and 56% in the previous year – 11 times greater than the general population [8]. A recent nationwide study in the Netherlands examined prevalence rates of several types of victimization and found that almost 20% of people with SMI were a victim of serious crimes in the previous year, such as sexual harassment/assault, violence, and physical assault [11]. In most cases, the victim knows the perpetrators of these crimes.

Likewise, internalized stigma and perceived discrimination are highly prevalent in people with SMI [16,17]. Brohan et al. [17] found that more than 40% of people with schizophrenia or other psychotic disorders reported internalized stigma and almost 70% perceived discrimination. Self-stigma entails becoming aware of the negative stereotyping of people with mental illness and eventually applying it to one's self. This may result in lower self-esteem and self-efficacy, and eventually leads to avoiding behavior that interferes with achieving life goals and social integration – the so-called "why try" effect [18]. High levels of self-stigma and perceived discrimination were also associated with a lower number of social contacts, and difficulties finding employment [17,19,20]. Many experience this stigma and discrimination on a regular basis in their daily and social activities.

Adversities such as victimization, stigmatization and discrimination, whether experienced or anticipated, are important barriers for personal recovery and social participation [14]. Anticipating stigmatization or discrimination, people with SMI tend to refrain from involvement in social interaction or daily activities to prevent future rejection or risk victimization [16]. This can lead to social deprivation, loneliness, and consequently to a loss of confidence, lower self-efficacy and lower quality of life [16,17,21]. For this reason, in this study victimization is related to all adversities people with SMI may experience in their social and community functioning, including stigmatization, discrimination and criminal victimization, e.g., robbery, sexual assault, and property crimes.

Flexible Assertive Community Treatment (FACT) is a predominant type of community mental health care (MHC) for people with SMI in the Netherlands. FACT teams are meant to support clients with rehabilitation goals and wishes to regain valuable roles in community [22]. Nevertheless, these teams experience difficulties in thoroughly supporting clients in employment, social support and social functioning [21]. In practice, the focus and availability of these teams tend to be more on diagnosis, treatment, and crisis management, rather than on rehabilitation and community support [23].

Another reason for the lack of attention for societal participation, and the impact of adversities on this, is that many mental health professionals (MHPs) fear an increase of symptoms or relapse by addressing adversities related to societal participation [24]. Despite the high prevalence and major effects of victimization, discrimination and stigmatization, it is not self-evident that MHPs address victimization or other adversities, at least not in a systematic way, both at intake and throughout their treatment [21,25]. However, current studies suggest that talking about victimization and other adversities does not lead to an increase of symptoms or relapse. On the contrary, it was shown that it leads to more acknowledgement for and understanding of the situation, for both the MHP and the client [26-28]. Moreover, it provides tools to prevent or to cope with possible risks when engaging in future social situations.

Social recovery is inevitably associated with ups and downs when it comes to regaining valued roles in society. This is recognized by advocates of the consumer advocates, who developed the concept of "dignity of risk" [29,30]. Dignity of risk emphasizes personal choice and self-determination, which are also two central concepts in social recovery [31], and assumes that people with SMI have the right to self-manage decisions about wellness, employment, and social contacts, and profit more from taking risks than from avoiding them. Taking into account the high rates of victimization in this group, risks taken on their road to recovery, however, should be well assessed and managed. This positive risk management perspective has also been promoted by the UK department of Health [32]. On the one hand, it is necessary for both clients and professionals to make realistic assessments of the clients' abilities regarding societal participation; on the other hand, clients need to acquire skills to minimize adversities [24].

The Victoria intervention for community MHC workers is the first to incorporate this positive risk approach in a psychiatric rehabilitation method. Although there is growing recognition for the benefits of exposure and other trauma-focused treatments for persons with SMI, including persons suffering from psychosis [33], prevention and victimization in relation to social participation are not addressed yet. Likewise, in the field of recovery-oriented care there is increasing evidence that addressing (risks on) victimization or other adversities may also be beneficial for clients on their road to recovery [26-28]. However, in community MHC, practitioners do not adopt this positive risk approach yet, and do not address adversities in the social context in a structural or systematic way [34].

The Victoria intervention is a method for community MHC workers to increase their awareness about the topic and support them in assessing victimization and incorporate appropriate services, including trauma screening and rehabilitation services, in their health care planning. For clients, the Victoria intervention aims to increase their awareness, active management of possible victimization risks and promotes safe social participation [26,35].

Objective and research questions

The Victoria intervention is a novel intervention. Although the intervention is thoughtfully designed and piloted, due to its novelty it is important to study the implementation process and its context. Therefore, we will perform both a trial and a process evaluation to study the effectiveness and feasibility of this intervention. In addition, it is not only important to examine whether the intervention is effective as a whole, it is also relevant to further examine which clients will or will not benefit from the intervention [36].

The aim of this initial trial on the Victoria intervention is to gain insight into the implementation process and effectiveness of the Victoria intervention, on both the team level and the client level, in reducing victimization, including other adversities, and increasing societal participation. The primary research questions are:

1. To what extent is the Victoria intervention implemented as intended and how is this new intervention perceived by the MHP?
2. Does applying the Victoria intervention lead to increased societal participation and decreased victimization compared to care as usual (CAU) for clients of outpatient teams with SMI?

Secondary research questions are:

1. Is the Victoria intervention an effective intervention for clients with SMI with regard to acknowledgement of adversities, quality of life, psychosocial functioning, and self-efficacy, compared to CAU?
2. Is the Victoria intervention an effective intervention compared to CAU, with regard to awareness and acknowledgement of victimization by MHPs, and their insight in societal participation of the client?

Methods

Design

This study includes: 1) a process evaluation and 2) a two-armed multi center cluster randomized controlled trial (RCT) to follow the implementation process and determine the effectiveness of the Victoria intervention. Participants include adult clients of eight FACT teams who are interviewed about their victimization experiences and rehabilitation process at three points in time: at baseline, and after 9 and 18 months. Study characteristics are described according to SPIRIT guidelines [37]. This study was approved by the Medical Ethical Committee of the Elisabeth Hospital in Tilburg (NL53845.028.15) on the 18th of November 2015 for all participating sites. The study is registered with the Dutch Trial Register (NTR 5585).

Setting and team structure

The Victoria study will be performed in FACT teams in two MHC organizations, one in the north-west and one in the south of the Netherlands. FACT is a flexible model of assertive community treatment (ACT), in which it is possible to switch from intensive treatment (e.g., ACT) or crisis management at the one hand to individual case management and multidisciplinary treatment on the other, and is considered the predominant type of community MHC for persons with SMI in the Netherlands [38]. FACT teams are, like ACT teams, multi-disciplinary, and consist of a variety of MHPs including a psychiatrist, psychiatric nurses, and an expert-by-experience. One of the benefits of FACT is that clients receive care within one team and can build a relationship; this continuity of care creates better opportunities for recovery and rehabilitation [38]. The eight participating teams have a total caseload of over 1500 clients.

Clients

The client population consists of people with SMI, receiving outpatient care in one of the participating FACT teams. In the Netherlands, approximately 281.000 people have SMI, of whom 160.000 actually receive MHC [39]. Although these people have common problems and needs, this is a heterogeneous group with a range of psychiatric disorders. People with psychotic disorders form the largest group (60%); other prevalent diagnoses are bipolar disorder, anxiety disorder, personality disorder, and drug- or alcohol addiction, often in combination with each other. From the participating teams, all clients will be asked to participate in the study, following an informed consent procedure.

Clients are eligible for participation if they receive care from the participating teams at the moment of recruiting. Clients will be excluded from the study if they, according to their case manager, meet one of the following criteria: younger than 18 years old, not having sufficient understanding of the Dutch language, not being capable of completing the interview due to cognitive impairment, having severe symptomatology, or psycho-organic disorder, and being admitted to a psychiatric hospital, or staying in prison during the recruitment period (Fig. 1).

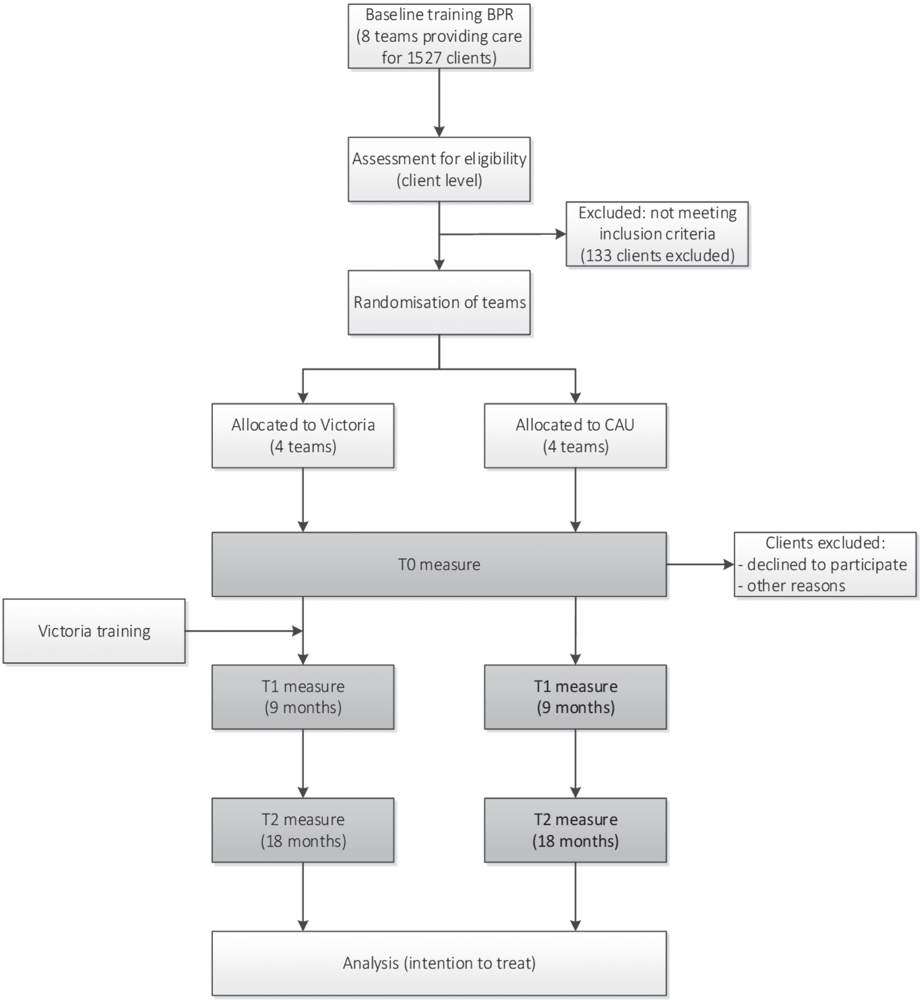

Figure 1. Flow chart of the study design.
Note: 'Other reasons' are for example: prolonged admission, death, or imprisonment.

Victoria intervention

The Victoria intervention is developed together with ‘Stichting Rehabilitatie ‘92’, and consists of four steps (Exploring, Analyzing, Clarifying context, Future steps) in discussing victimization and other adversities related to societal participation with the client. The MHP who have received training in this module are able to use this intervention for clients that are facing difficulties with societal participation. The goal of these conversations is acknowledgement of these adversities and their impact on daily life by the MHP, and for the client to become more aware of risky situations. In these conversations, the client is given tools and supported to adequately cope in future risky situations. This asks for attitude changes in MHPs during training with the ultimate aim to expand societal participation and decrease victimization for the client. The Victoria intervention can be regarded a preamble intervention, to be used as part of the starting phase in rehabilitation methods, such as the BPR. Additionally, when a client experiences difficulties in one of the rehabilitation phases, and stagnates in societal participation, it can be used as a restart intervention.

Within the conversation context of Victoria, the MHP creates room for the client to tell his or her own story including experiences with victimization and other adversities, and supports the client in rediscovering his/her goals and wishes for societal participation. By following the four steps, Victoria supports the MHC to shift focus from, which is currently the case in FACT teams, crisis management to more recovery-oriented care.

The first step of the Victoria intervention is *Exploring* and involves checking the level of activity in the following domains: housing, social contacts, education, and work. The MHP assesses whether the client is avoiding activities, or if progress on these domains is stagnating. If this is the case, together they examine whether this avoidance or stagnation is linked to experiences with victimization or other adversities related to societal participation.

The second step is *Analyzing* and involves investigation of this negative experiences together (who, what, where, when). It is crucial that the MHP uses active listening techniques while the client is elaborating on these adverse events. Furthermore, the professional tries to understand the intensity and related feelings of the specific experiences, but also tries to uncover the causes for the avoidance or stagnation. The overall goal in this step of the intervention is to get a full picture of the negative events, to recognize and acknowledge feelings related to these events, and to understand what caused the client to stop or avoid societal participation.

The third step entails *Clarifying the context* of the adverse events. The MHP examines together with the client what desire or wish undergirded the events, i.e., what was the client’s motive to engage in this activity. Again, it is critical that the MHP actively creates room to let the client tell his or her story. If the underlying desire or wish is clear, the client explains to the MHP how he/she would have wanted the situation to go, and what he/she hoped to achieve by engaging in this activity. This is the link to further rehabilitation services.

The fourth and final step of the intervention comprises *Discussing future steps*. Overall, there are three possible outcomes of the Victoria intervention. Firstly, another appointment may be necessary to further discuss the adverse events. Secondly, if the client feels the MHP acknowledges the intensity of these adverse events and corresponding feelings, the next step may be to start a rehabilitation action plan to work on the original rehabilitation goal, using rehabilitation services. Finally, if the victimization experience was intense, the MHP should investigate whether trauma treatment is needed. If there are indications for trauma, the 10-item Trauma Screening Questionnaire (TSQ) is used [40]. If 6 or more items are answered positively, trauma treatment with the FACT psychologist is advised.

Training professionals to use the Victoria intervention

In this study, the intervention teams receive will three half-day training sessions. Two trainers from ‘Stichting Rehabilitatie ‘92’ and one expert-by-experience facilitate the training sessions. These sessions will focus on explaining the background of the intervention (including theory) and explaining the four steps of the intervention. Additionally, the second and third training sessions will include practicing in small groups and plenary role-play. Preferably, real life cases of the teams are used and discussed. If these cases are too complex to use in role-play, several fictitious cases are available in hand outs. All MHPs receive the Victoria handbook, as well as a shorter hand out in the form of a factsheet, and the case examples. For the professionals to be able to use the Victoria intervention, no specific materials are necessary. In order to ensure that MHPs will bring the intervention into practice, supervision meetings will be offered every 6–8 weeks, during 18 months. In these meetings difficulties in practice based on real life cases are discussed. One of the Victoria trainers leads these meetings. In order to ensure that training sessions across the country will be similar, the content of the training was prepared together with the trainers, and all training sessions will be recorded and spread among other trainers. Finally, a short educational film will be shown in one of the supervision meetings, containing a good example of a Victoria conversation between a real rehabilitation coach and an expert-by-experience. The goal of this film is both improving practice and enlarging comparability of the training and supervision meetings across the country.

Part of the training and supervision meetings will be brainstorming about incorporating the Victoria intervention in day-to-day work. Incorporating Victoria in daily routines may include a short report of a conversation between the MHP and the client, but may also include discussion during a team meeting.

Care as usual
Professionals in the control group will continue to work according to CAU in FACT teams, including FACT practice and rehabilitation according to the BPR, which is the common rehabilitation approach in both participating organizations. The goal of the BPR is: "to assure that the person with a psychiatric disability possesses those physical, emotional, and intellectual skills needed to live, learn, and work in his or her own particular environment" [2]. The BPR supports clients in formulating their rehabilitation goals and wishes, in how to choose, get, and keep a preferred and valued role on several domains such as housing, social contacts, education, and work [2,41].

To ensure that both sites are comparable on their knowledge and skills regarding the BPR, and to avoid differences in effect due to differences in rehabilitation skills of the team members, all participating teams receive the basic training in the BPR by the official Dutch BPR training center 'Stichting Rehabilitation '92', prior to randomization. This entails a 7-day training for all case managers, experts-by-experience, and occupational workers, where they will be taught theoretical principles and acquire practical skills. After training, professionals also receive supervision for 6 months where individual cases are discussed. After those 6 months, teams in the control group will continue to work according to principles of FACT and the BPR for the total duration of the trial. The BPR training and supervision is conducted prior to training and supervision of the Victoria intervention.

Process evaluation

Because the Victoria is a novel intervention, in this first full cluster RCT, a process evaluation is highly relevant. A process evaluation is even more important in so-called 'complex interventions' [42,43]. Complex interventions ask for a change of perspective in the MHP, but also operate in an organizational context that is difficult to influence or rule out [43]. When an RCT answers the question of whether the intervention works (or not), a process evaluation is performed to *understand* the possible effects of the intervention [42]. Therefore, a process evaluation is an enhancement of the RCT. In this process evaluation, the implementation and use of the Victoria intervention is evaluated on the following aspects: fidelity, feasibility, relevance and acceptation. More specifically, the focus will be on understanding the experiences of the clients who receive the intervention, but even more so on the professionals' experiences with and perceptions of the intervention.

To achieve this, a multi-method design will be used. First, qualitative interviews will be carried out with several professionals and clients. MHPs of the outpatient teams are purposefully selected, including the trainers of the intervention and management staff from the two involved sites. Twenty clients participating in the RCT will be selected and asked for consent. These interviews will take place from a year after the training for the RCT. A topic list will be used to steer the interview. The interviews with the professionals will focus on understanding perceptions regarding the relevance of: the intervention, the training and the supervision meetings, the implementation as a whole, and the feasibility of using the intervention in real life. The clients will be asked if they noticed obvious differences in the conversations with their case managers with regard to adversities in the social context, and how they perceive these differences. Data will be audio recorded, transcribed verbatim, and coded using the ATLAS software program. Second, the supervision sessions will be recorded and analyzed to examine whether professionals implemented the Victoria intervention as intended, and to get a better picture of their experiences with and perceptions of the intervention. Third, during the supervision sessions, the professionals will be asked to fill out a checklist to inquire their knowledge about the steps of the intervention. This is done to measure fidelity of the intervention. Fourth, in the RCT questionnaires for the intervention teams, questions are added about the extent to which the professional has executed the intervention in real practice, and on the insight the professional has in potential adversities that act as a barrier for clients' participation. Both the checklist and the questionnaire are analyzed using SPSS (version 22).

Cluster RCT

Recruitment and consent

Clients eligible for participation receive a letter and brochure with information about the study, as approved by the ethical committee. In this letter, the themes of the study, questionnaire and time frame are explained. Clients are also informed that during the study they can withdraw at any time. After a two-week consideration period, the researchers will contact the client to ask if more information is needed and if they are willing to participate. If the client is willing to participate, a date, time, and place for the interview is scheduled. Clients will be asked to give their written informed consent before the start of the baseline interview. Participants will receive a compensation of 5, 10, and 15 euros for T0, T1, and T2 respectively.

Because randomization is performed at a team level and the Victoria intervention is considered a team approach, no separate informed consent is needed for the group randomization and consequently having the Victoria conversation. However, if the client wishes not to talk about societal participation and related adverse events, MHPs have to respect that.

Randomization and blinding

The participating teams will be randomly allocated to either the experimental or control condition by an independent senior researcher at Tilburg University, stratified by mental health organization. Cluster randomization was chosen as individual randomization would mean reassigning clients from their regular case managers and was therefore considered to be ethically undesirable. Moreover, cluster randomization reduces risks of contamination between the intervention and control group, as the intervention method is team based. We will monitor staff changes as well as clients switching teams to correct for in statistical analyses.

Due to the nature of the intervention, both the MHP and researchers cannot be unaware of the allocation to the conditions, but they are strongly advised not to disclose to the participating clients whether they receive care from an experimental or control team.

Measures

Table 1 provides an overview of the measurement instruments used. These instruments were chosen according to their comparability in national and international mental health research, and their psychometric characteristics. Duration and sensitivity to measure change were also taken into consideration. The first author as well as trained interviewers will carry out the interviews, which will take place on a location preferred by the client, at home or at team location. The interviewers were trained by explaining the topic list and using role-play, in order minimize bias due to inter-reviewer differences. Moreover, the first one or two interviews will be performed in dyads, with the researcher. Data will be entered into a secured database by researchers or research assistants. Participants' names will be changed into randomly assigned numbers of which only two of the authors have the key.

Table 1. Overview of measurement instruments

Concept	Instrument	Level	T0	T1	T2*
Primary outcome measures					
Societal participation	Birchwood Social Functioning Scale (SFS)	Client	x	x	x
Criminal victimization	The Safety Monitor, section 4	Client	x	x	x
Discrimination and stigmatization	Discrimination and Stigma Scale (DISC-12)	Client	x	x	x
Perceived safety	The Safety Monitor, section 3	Client	x	x	x
Secondary outcome measures					
Acknowledgement of adversities	Structured questionnaire on feelings when discussing adversities	Client	x	x	x
Knowledge on rehabilitation and adversities	Structured questionnaire	MHP	x	x	x
Self-efficacy	Mental Health Confidence Scale (MHCS)	Client	x	x	x
Quality of Life	Manchester Short Assessment of Quality of Life (MANSA)	Client	x	x	x

Table 1. *Continued*

Concept	Instrument	Level	T0	T1	T2*
General psycho-social functioning	The Health of the Nation Outcome Scales (HoNOS)	MHP	x	x	x
Additional and control measures					
Socio-demographic characteristics	Structured questionnaire	Client	x	x	x
Primary diagnosis	Structured questionnaire	MHP	x		
Number of years in MHC	Structured questionnaire	Client	x		
Social Support	Inventory of Social Reliance	Client	x	x	x
Neighborhood nuisance	The Safety Monitor, section 1 and 2	Client	x	x	x
Perpetration	The Safety Monitor, section 5	Client	x	x	x
FACT fidelity	CCAF scores	Team	x		x
Adherence to rehabilitation principles	Treatment plan (sample of 15% per team)	Client	x		x

*T0 baseline, T1 9 months follow-up, T2 18 months follow-up

Primary outcome measures cluster RCT

1. The first primary outcome measure is social participation measured with the Birchwood Social Functioning Scale (SFS) [44]. It measures social functioning on seven domains: social engagement/ withdrawal, interpersonal behavior, pro-social activities, recreation, independence-competence, independence-performance, and employment/occupation. The SFS is a reliable, valid, sensitive to change, instrument with a high internal consistency (α = .80) [44].

The second primary outcome measure is victimization related to societal participation and includes the following:

2. *Criminal victimization* will be measured with the Dutch version of the Safety Monitor, developed by the Dutch Ministry of Security and Justice [45], and strongly resembles the International Crime Victimization Survey [46]. It is a self-report questionnaire in which section 4 measures victimization on 15 crimes: burglary, theft from car, car theft, theft of other motorized vehicles, bicycle theft, (attempt to) robbery, theft (other than previously categorized), sexual intimidation or assault, threats (of violence), physical assault, vandalism, identity fraud, fraud with buying/selling items/services, hacking, cyber bullying. For each incident reported in the past 12 months, participants are asked to give more information about the incident.

3. *Perceived safety* will also be measured with the Safety Monitor. The participant is asked whether they ever feel unsafe (*yes/no*) and how often (*often/ sometimes/ rarely*).
4. *Discrimination and stigmatization* is assessed by the Discrimination and Stigmatization Scale (DISC-12) [47]. This scale consists of four subscales: unfair treatment, stopping self, overcoming stigma, positive treatment. The DISC-12 contains 32 items answered on a 4-point scale ranging from '*no difference* (0)' to '*a lot* (3)'. A 'not applicable' answer is available when the participant was not involved in the described situation. Psychometric properties are considered good, Cronbach's alpha is .78 and the inter-rater reliability ranges from .62 to .95.

Secondary outcome measures

The following secondary outcome measures will be used to gain more insight into the effects of the Victoria intervention.

1. *Acknowledgement of adversities* related to societal participation is assessed through a self-report questionnaire developed for this study.
2. *Knowledge on rehabilitation and adversities* will be measured through questions for MHP on the domains and phases of the BPR, and through questions on recent conversations about adversities. These questions are also developed for this study.
3. *Self-efficacy* in mental health-related beliefs is measured through the Mental Health Confidence Scale (MHCS) [48], with a 6-point Likert scale, ranging from '*totally no confidence*' to '*full confidence*'. Cronbach's alpha for the total scale is .93 [49].
4. To measure the *quality of life* the Manchester Short Assessment of Quality of Life (MANSA) is used [50,51]. The MANSA has good internal consistency ($\alpha = .72$) and is highly correlated ($r \geq .83$ for each domain) with the Lancashire Quality of Life Profile (LQLP) [50]. The scale consists of 12 questions with a 7-point Likert scale ranging from '*couldn't be worse*' to '*couldn't be better*' and 4 questions that are answered with yes/no.
5. *General psycho-social functioning* is measured through the Health of the Nation Outcome Scale (HoNOS), a scale that is standard in MHC in the UK [52]. The MHP scores each item on a scale from 0 to 4. The intraclass correlation coefficient is .92, Cronbach's alpha is .78 and it correlates well with other scales [53]. Moreover, the HoNOS is sensitive to measure change in people with SMI.

Additional and control measures

The following measures include instruments that are possible confounding, mediating or control variables.

1. *Socio-demographic characteristics* will be gathered at the start of the interview, including: age, gender, date of birth, number of children, marital status, nationality, education, living situation, income, and number of years in MHC.
2. *Current diagnosis* is gathered from the questionnaire for the MHP.

3. *Social Support* will be derived from the Inventory of Social Reliance (ISR) [54]. It consists of 11 items on emotional and practical support on a 4-point scale ranging from 'almost never' to 'almost always'. The ISR is a frequently used questionnaire for people with SMI and has good psychometric properties [55].
4. *Neighborhood nuisance* is measured through Sections 1 and 2 of the Safety Monitor (see primary outcome measures for more information). These sections contain 9 questions about the experienced safety and contentment in and about their neighborhood
5. *Perpetration* is assessed with the Safety Monitor. For the same criminal victimization incidents the participants are asked whether they were a perpetrator ever in their life, and if yes, also in the last year.
6. *FACT fidelity* is assessed through the fidelity scores from the CCAF, the Dutch organization that certifies FACT teams. The fidelity score is a mean score on 60 items that ranges from 0 to 5, where 0 means 'no certificate' and 5 means 'optimal implementation'.
7. *Adherence to rehabilitation principles* is measured through a sample of the treatment plans of the clients that participate. This treatment plan consists of agreements, goals and wishes on several life domains for the following year.

RCT Analyses

Sample size

Sample size is calculated using the model of Twisk [56]. This model is suitable for multiple measurements over time, but can also be used for cluster randomization. With the ratio of the number of subjects in the compared groups being 1 (r), a correlation coefficient of the repeated measurements of 0.20 (ρ), a conservative difference between the groups in the mean value of social functioning of 0.25 (v), and a power of $1-\beta = 0.80$, the number of participants needed is 151 for each condition at T2 measurement ($\alpha = .05$, two-tailed). Taking into account an attrition rate of 15% for loss due to follow-up or consent withdrawal, 173 participants per condition need to be recruited to achieve the required power.

$$N = \frac{Z(1-\alpha/2) + Z(1-\beta)\ 2\ \sigma 2(r+1)[1 + (T-1)\rho]}{v2r\ T}$$

Statistical analyses

Data will be analyzed according to the 'intention to treat' principle, meaning that FACT teams (and thus clients) that are assigned to either experimental or control condition in randomization, will be analyzed accordingly. Because of the cluster design and multiple measurements over time, generalized linear mixed models (GLMM) will be used with SPSS (version 22); depending on the distribution of the outcome variable a logistic regression model or a linear regression model will be adopted. GLMM is robust with respect to missing data [57], which is not uncommon in research among outpatients with SMI. Therefore, multiple imputation is not necessary. To analyze the effect of the Victoria intervention on the main outcomes, differences in societal participation and victimization, both conditions will be compared after 9 and 18 months follow-up with time as a categorical variable. Measurements over time are nested within participants; therefore, random slopes will be added for time. Random intercepts will be added for the participants. The same procedure will be adopted for secondary outcome measures. Furthermore, possible confounders will be examined, such as socio-demographic characteristics, current diagnosis, number of years in MHC, or perpetration on whether they need to be added to the model. Only significant confounders will be added to the final model. In all analyses performed, two-tailed p-values < 0.05 are considered significant. Finally, Akaike's Information Criterion (AIC) will be used for the selection of the final model that fits the data best and is the most generalizable [58].

Discussion

Outpatients with SMI experience high rates of victimization, discrimination and stigmatization [11-17]. These adversities are important barriers to rehabilitation and societal participation [21]. This study is the first to evaluate an intervention aiming at recognition of victimization and other adversities, that also targets outpatients' insight and coping skills with regard to possible risks to ensure safe societal participation. The aim of this first trial on the Victoria intervention is to gain insight into the implementation process and effectiveness of the Victoria intervention in reducing victimization (among other adversities) and increasing societal participation, on both the team level and the client level.

A major strength of this study will be the large sample size of outpatients with SMI, leading to sufficient power, which is often a problem in similar trials [59]. Only clients that are unable to fill out the questionnaire during the inclusion period of 6 months, due to insufficient understanding of the Dutch language, prolonged clinical admission, or severe symptomatology, will be excluded from the study. This, as well as the participation of multiple mental health centers, enhances generalizability of results.

This is, to our knowledge, the first study to address victimization and other adversities as a barrier for societal participation. In relation to this, we incorporated a broad range of outcome measures. Many previous studies on victimization only take into account clinical outcome measures or socio-demographic variables such as living situation [13,14]. Although some studies include the influence of victimization on, for example, quality of life, this study includes a broad range of social outcome measures, such as social functioning and social support. These outcome measures are likely to be influenced by victimization or other adversities in the social domain [60,61].

A final strength of the study is the multi-method approach. A process evaluation will be conducted to examine the implementation process of the intervention. Studies with a similar target population that examine complex interventions in a RCT often find no treatment effect, due to, for example, implementation or fidelity issues [62]. Within the design of an RCT, normally, there is little room for examining the implementation process, leading to a black box in explaining the results. Therefore, the UK Medical Research Council advises conducting a process evaluation, to understand context mechanisms and provide insights on implementation and fidelity [63]. For this reason, we do include a process evaluation and a longitudinal follow-up on effects, using a cluster RCT.

One of the main challenges in this study lies in the fact that the Victoria intervention is a complex intervention, encompassing characteristics of the local context, and the complexity of causal relations between intervention and outcomes [36]. MHPs in the participating teams sometimes work in multiple teams or, due to reorganization, they shift from one team to the other. This brings challenges in the implementation of the intervention. To address this, a strong collaboration is created between the two MHC institutions and the university in this project, with shared goals and input. Additionally, the process evaluation will be helpful in following the implementation process.

Another challenge of this study, and of most other studies among outpatients with SMI and follow-up measurements, is the dropout risk in the cluster RCT. In the sample size calculation, we take this into account by estimating a 15% loss to follow-up, and using effect sizes that may be considered conservative, compared to effect sizes found in other studies [64]. This leads to 347 required respondents at baseline measurement. Moreover, with the help of the MHPs, a contact plan, and by giving clients incentives for participating, we aim to prevent dropout as much as possible.

Finally, due to novelty of the Victoria intervention, there is no valid fidelity measure. Therefore, in this project a new fidelity checklist will be developed and used. To increase validity in measuring fidelity, we use triangulation by also including qualitative analyses of the recordings of the supervision meetings and questionnaires for both clients and MHP, as explained in the methods section.

In conclusion, the Victoria intervention is the first to incorporate a positive risk approach into a psychiatric rehabilitation method. This study is expected to provide scientific insights in ways to reduce victimization, (self-) stigmatization and discrimination, and increase societal participation, but also in the impact of other factors such as acknowledgement and awareness of these adversities. Moreover, results of this study may validate the Victoria intervention as one of the practices to better manage risk on adversities related to societal participation.

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5

Intervention to prevent and manage the effects of victimization related to social participation for people with severe mental illness

Results from a cluster randomized controlled trial

Published as:
Albers WMM, Roeg DPK, Nijssen YAM, Deen ML, Bongers IMB, van Weeghel J. Intervention to prevent and manage the effects of victimization related to societal participation for people with severe mental illness: Results from a cluster randomized controlled trial.

Psychiatr Rehabil J. 2021;44(3):254-265.

Abstract

Objective

Individuals with severe mental illness often face (anticipated) discrimination and (criminal) victimization, which have severe consequences for their social participation. The aim of the present study is to assess the effectiveness of a new intervention to manage and prevent re-victimization, and to support safe participation by recognizing and acknowledging the impact of their victimization experiences.

Method

A multicenter cluster randomized controlled trial was performed by following clients from four intervention teams and four teams providing care as usual. The primary outcomes were social participation, victimization, and discrimination. The secondary outcomes were acknowledgement of difficulties, self-efficacy and empowerment, quality of life, and psychosocial functioning. Data were collected at baseline, and after 10- and 20-month follow-ups. The data were analyzed according to the intention-to-treat principle using linear mixed models and generalized estimating equations. In total, 400 clients were included in the analyses: 216 in the intervention group and 184 in the control group.

Results

For experienced discrimination and acknowledgement of difficulties and recovery support we found small but significant time by condition interactions after 20 months. Both experienced and anticipated discrimination, and self-efficacy increased slightly in both groups. No significant differences were found for other outcome measures.

Conclusions and Implications for Practice

The intervention had no effect on victimization and participation, but there were indications that it was successful in moderating experienced discrimination. The clients also felt significantly more acknowledged and supported in their recovery process. Further development of the intervention is needed, and future research should focus on improving implementation.

Keywords

social participation, victimization, discrimination and stigmatization, severe mental illness, randomized controlled trial

Impact and implications

Our study offers insights into how to reduce the uncertainty around discussing victimization that hampers participation, by assessing an intervention to support mental health practitioners to initiate the conversation on victimization with individuals with mental illness. This intervention had no effects on participation and victimization. It was found to successfully moderate experienced discrimination. Clients feel that their victimization experiences are acknowledged and that they are supported in their recovery process.

Introduction

Alongside the positive focus on rehabilitation and social participation in community mental health care for individuals with severe mental illness (SMI), there is an increasing risk on victimization, such as robbery and physical assault, and (anticipated) discrimination [1]. Multiple studies have shown that people with SMI frequently experience discrimination, which is the behavioral aspect of public stigma, many of them even on a daily basis [2,3]. Criminal victimization is also highly prevalent among individuals with SMI [4], even more so than in the rest of the population [5]. For example, Dutch outpatients with SMI had over six times more crime incidents than the general population and were most prone to personal crimes, such as sexual harassment or assault, threats of violence, and physical assault [6].

Victimization—that is, criminal victimization and (anticipated) discrimination—can have severe consequences. Criminal victimization not only causes obvious physical trauma but it also negatively affects a person's self-esteem and self-efficacy [5]. Moreover, it leads to an increase of psychiatric symptoms, substance use, loss of confidence, and reduced quality of life [1,7]. Likewise, experiences of being rejected can negatively influence a person's self-esteem and instigate self-stigma [8]. In turn, this can discourage individuals from pursuing any actions in their recovery process, which is called the "why try"-effect [9], and can even lead them to refrain from participating in social activities (i.e., anticipated discrimination) [2].

Individuals with SMI have lower social participation rates than the general population. Only 10-20% of individuals with SMI are employed [10]. When compared to the general population, they have lower quality and fewer social networks, and they experience less social support [11]. Several studies have identified victimization and discrimination as risk factors for stagnation in recovery [1], and more specifically, in social participation [12]. This relationship tends to be reciprocal [13]. For instance, Fitzgerald et al. [14] found that both inpatients and outpatients who were not engaged in meaningful daily activities, experienced elevated levels of victimization.

Victimization used to be a neglected topic by mental health professionals because of the fear of exacerbating the symptoms, especially in psychotic disorders [15,16]. However, recent studies have indicated that instead of having negative effects, addressing victimization can be beneficial [15,17]. Nevertheless, professionals have almost no tools to address the topic and impact of victimization [1,16]. There is also a lack of research about how to prevent victimization from becoming a barrier to social participation [13]. Therefore, we developed the Victoria intervention, which is a victimization-informed intervention for professionals. By recognizing and acknowledging the impact of their client's victimization experiences, the Victoria intervention intends to manage and prevent re-victimization and support safe participation.

In this article, we report on how the Victoria intervention affects individuals with SMI in a range of outcomes. We hypothesized that applying the Victoria intervention would lead to increased social participation and decreased victimization. In the definition of victimization, we include criminal victimization and (anticipated) discrimination. Furthermore, we expected that the Victoria intervention would positively affect the acknowledgment of victimization related to social participation, self-efficacy and empowerment, quality of life, and psychosocial functioning.

Methods

Design

Full details of the design were published previously [18]. In short, a multicenter cluster randomized controlled trial was conducted. We randomized at the cluster level rather than at the individual level because it rules out the potential for contamination (i.e., community mental health teams work with a shared caseload and have several team meetings per week). Individual randomization would also mean reassigning clients away from their regular case managers, with whom they sometimes have a yearlong connection. The participating teams were randomly allocated to either the intervention or the control condition by an independent researcher at the Tilburg University using simple randomization. An equal number of teams were appointed to each condition and they were stratified based at the center. This led to us adopting one experimental team and two control teams at one center, and three experimental teams and two control teams at the other center. From one center, the two small teams were combined in the randomization process to ensure that both arms had an equal number of clients, without requiring clients to switch teams. Professionals and the research coordinator could not be blinded to allocation because the professionals performed the intervention, and the research coordinator organized the training sessions. However, they were instructed not to disclose allocation to their clients. Outcomes were measured at baseline and after 10 and 20 months (T0, T1, and T2, respectively).

This study was approved by the Medical Ethical Committee of the Elisabeth Hospital in Tilburg (NL53845.028.15) on November 18, 2015 for all participating sites. The study was registered with the Dutch Trial Register (NL4172).

Participants

The participants were clients from the Flexible Assertive Community Treatment (F-ACT) teams. In the F-ACT model, a multidisciplinary team provides individual case management and assertive community treatment with a shared caseload. This ensures continuity of care in periods of stability, when there is more room for rehabilitation, and also in periods of psychological crises. A F-ACT team generally consist of a psychiatrist, employment specialist, psychologist, mental health nurses, and experts-by-experience [19]. These teams provide care to clients with a SMI, which was defined in a

Dutch consensus document [20]. In short, an individual must have an ongoing psychiatric disorder (according to the Diagnostic and Statistical Manual of Mental Disorders-IV [DSM-IV]), have severe limitations in social and community functioning, and these problems are systematic and long-term. The clients were recruited from eight teams at two sites in the Netherlands: five teams in the South and three teams in the Northwest. The catchment areas of the eight teams varied as follows: two were located in rural areas, two around small cities, and four in urban areas.

The inclusion criteria for this study were as follows: Receiving care from a F-ACT team; aged ≥ 18 years; and willingness to participate. The exclusion criteria were an insufficient comprehension of the Dutch language; inability to complete the interview due to cognitive impairment; florid psychosis or psychiatric crisis (i.e., having a serious relapse); a psycho-organic disorder; or experiencing an admission to a psychiatric hospital or prison.

Table 1 lists the characteristics of the sample. The majority of the respondents were male and lived independently. The most prevalent primary diagnoses were schizophrenia or another psychotic disorder.

Table 1. Demographic and baseline characteristics (N = 400)

	Intervention		Control		
	(n = 216)		(n = 184)		Statistic
Client characteristic					
Age in years, *M* (*SD*)	44.38	(9.54)	46.63	(10.00)	2.90*[a]
Gender, no. (%)					
Female	83	(38.43)	73	(39.67)	.07[b]
Male	133	(61.57)	111	(60.33)	
Born in the Netherlands, no. (%)					
Yes	172	(79.63)	161	(87.50)	4.41*[b]
No	44	(20.37)	23	(12.50)	
Education, no. (%) [d]					
Low	109	(51.90)	88	(48.62)	-.03[c]
Middle	77	(36.67)	70	(38.67)	
High	24	(11.43)	23	(12.71)	
Living situation, no. (%)					
Living with parents or family	9	(4.19)	9	(4.89)	.11*[c]

Table 1. *Continued*

	Intervention		Control		
	(n = 216)		(n = 184)		Statistic
Living on their own	164	(76.28)	155	(84.24)	
Supported (independent) living	38	(17.67)	20	(10.87)	
Other	4	(1.86)	0	(0)	
Marital status, no. (%)					
Not married	139	(64.35)	128	(69.95)	.07[c]
Divorced	34	(15.74)	30	(16.39)	
Married	35	(16.2)	20	(10.93)	
Widow/widower	4	(1.85)	4	(2.19)	
Cohabitation agreement	4	(1.85)	1	(0.55)	
Employment status, no. (%)					
Benefits	164	(75.93)	138	(75.00)	-.01[c]
Retired	0	(0)	1	(0.54)	
Employed	39	(18.06)	32	(17.39)	
Other	13	(6.02)	13	(7.07)	
Primary diagnosis, no. (%)					
Schizophrenia	55	(26.32)	53	(28.80)	.03[c]
Other psychotic disorder [e]	50	(23.92)	47	(25.54)	
Mood disorder	30	(14.35)	19	(10.33)	
Anxiety disorder	14	(6.70)	13	(7.07)	
Developmental disorder	20	(9.57)	18	(9.78)	
SUD	3	(1.44)	2	(1.09)	
Other Axis 1 diagnosis [f]	5	(2.39)	8	(4.35)	
Personality disorder	32	(15.31)	24	(13.04)	
SUD, no. (%)	89	(42.58)	59	(32.07)	4.61*[b]
Social support (ISR), sum (*SD*) [g]	27.37	(7.64)	27.61	(7.77)	.30[a]
Neighborhood social cohesion, sum (*SD*) [h]	18.58	(5.27)	18.98	(4.67)	.80[a]
Neighborhood nuisance, sum (*SD*) [i]	8.24	(6.40)	6.95	(6.54)	-1.98*[a]

Table 1. *Continued*

	Intervention		Control		
	(n = 216)		**(n = 184)**		**Statistic**
Perceived unsafety of neighborhood, no. (%)					
Not unsafe	149	(71.29)	139	(75.54)	.05[c]
Rarely	10	(4.79)	8	(4.35)	
Sometimes	38	(18.18)	29	(15.76)	
Often unsafe	12	(5.74)	8	(4.35)	
Perpetration, *M* (*SD*)					
Property perpetration	0.07	(0.27)	0.04	(0.25)	-.98[a]
Personal perpetration	0.14	(0.39)	0.12	(0.38)	-.74[a]
Digital perpetration	0.04	(0.19)	0.03	(0.16)	-.55[a]
Total perpetration	0.29	(0.61)	0.23	(0.83)	-.78[a]
Team characteristic[j]					
Individual rehabilitation plan, *M*	3.38		2.75		
Vocational rehabilitation, *M*	3.50		2.75		
Training recovery-oriented care, *M*	2.50		3.25		
Structural attention for recovery, *M*	3.50		2.50		
Overall F-ACT fidelity score, *M*	3.92		3.85		

Note. SUD = substance use disorder
[a] Independent sample t-test; [b] Chi^2 test; [c] Spearman's rho; [d] low = no education, primary or lower secondary education, middle = intermediate vocational or high school education, high = higher vocational education or university and higher; [e] Other psychotic disorders include brief psychotic disorder, delusional disorder, psychotic disorder due to a general medical condition, schizoaffective disorder, schizophreniform disorder, shared psychotic disorder, and substance-induced psychotic disorder; [f] Other Axis 1 diagnoses include cognitive disorder, dissociative disorder, eating disorder, intermittent explosive disorder, pedophilia, alcohol-induced persisting amnestic disorder, impulse-control disorder, and somatization disorder; [g] minimum = 12, maximum = 44; [h] minimum = 3, maximum = 30; [i] minimum = 0, maximum = 36; [j] minimum = 1, maximum = 5
* $p \leq .05$

Treatment

Control condition

The clients in the control condition received care as usual, which consists of F-ACT practice and the Boston University Approach to Psychiatric Rehabilitation (BPR) [21]. Both intervention and control teams received an update of BPR in a 7-day basic training course, including subsequent intervision meetings, given by Rehabilitation ’92 (a national training institute) prior to baseline measurement.

Intervention condition

The Victoria intervention is provided as an add-on module to care as usual (i.e., F-ACT and BPR). It was developed in collaboration with Rehabilitation ’92. This iterative process involved a literature search and focus groups and expert meetings with mental health innovation experts, professionals, and experts-by-experience. The resulting intervention was previously piloted in two teams, which indicated good feasibility. The development process was published elsewhere [22].

The intervention has four steps as follows: exploring, analyzing, clarifying the context, and future steps. The Victoria intervention is focused on the personal experience of the client and the first step is therefore to explore the victimization experience together in a one-on-one meeting with the client alone. Following F-ACT and Boston approach guidelines, significant others need to be involved in the next phase, according to the treatment and rehabilitation plan. The number and length of the sessions vary (ranging from 15 to 60 min). The first step, exploring, incorporates elements and skills taught in the goal attainment module of BPR [21]. It involves evaluating the client’s satisfaction and activity related to life domains, such as housing, contacts, education, and work. The other steps of the Victoria intervention are indicated when there are signals that a client is avoiding activities or if desired progress on these domains is stagnating. If this is the case, the possible role of recent victimization experiences in this is assessed. The second step, analyzing, discusses the most relevant negative experiences related to social participation, using an analysis scheme of who, what, where, and when. Adding to conversation techniques that are standard mental health practice, is a narrative approach in which the professional acknowledges the pain and struggle of the client’s victimization experience [23]. In addition, the professional understands why the client understand why it made the client stagnate in participating in the social situation. This acknowledgement and empathy build on the client’s sense of coherence. It has a positive influence on their resilience and contributes to their recovery [24]. The third step is to clarify the context of the experience. In this step, the professional and client examine together why the client initially engaged in the situation where the victimization experience happened. The client’s story and perceptions are crucial to fully understanding the underlying goals and wishes (i.e., a client-centered and narrative approach). The goal in this step is to switch the mindset from a negative stance (i.e., the victimization experience) to a more positive perspective (i.e., the activity the client was involved in or aiming at). Elements from the concept of the “dignity of risk” [25] and the positive risk approach [26] formed the inspiration for this step. Taking (reasonable) risks is necessary to progress in life, so in this step the focus is not to discourage participation [27]. The professional can move on from this step when he or she understands the motive for engaging in the situation in which the victimization occurred. The fourth and final step involves determining future steps based on the results of the previous steps. Application of the Victoria intervention is personalized: One client may need and want several conversations, while another may be satisfied with one or two conversations. Once the first three steps have been discussed extensively, the next step may be to (re)formulate a rehabilitation action plan, including positive risk management, by using the goal attainment module of BPR [21]. If the victimization experience was intense and trauma is suspected, then use of the Trauma Screening Questionnaire is advised [28]. All of the mental health professionals in this study were skilled to detect trauma and had experience in filling out this short questionnaire. Moreover, the participating teams were all embedded in larger mental health settings and professionals may, if necessary, easily refer to trauma treatment. Other follow-up interventions could include social support interventions [29], interventions counteracting self-stigma [30], or supported employment [31]. Evaluation of the client's satisfaction and activity related to several life domains, the first step of the intervention, should be repeated on a regular basis, because clients' situations, including difficulties with social participation, change over time.

The intervention teams received three half-day training sessions in the Victoria intervention, provided by Rehabilitation '92, the researchers, and an expert-by-experience. In the first session, the relevance of addressing victimization and ways to secure the intervention into the daily job routine of the multidisciplinary team was discussed. The second and third sessions included explanations of the four steps of the intervention, followed by role-playing exercises. After the training sessions, intervision meetings were planned bimonthly in all teams. On average, the teams received seven to nine intervision meetings over approximately 1.5 years. To ensure intervention use, two additional training sessions were organized for new team members entering the participating teams during the study.

Procedure

Recruitment of participants took place from March to October 2016, and data collection continued to July 2018. The professionals on the participating teams ran through their caseload to select or exclude clients based on inclusion and exclusion criteria. If a client was determined to be eligible for participation, then they were sent a letter and brochure to inform them about the study and invite them to participate in a face-to-face interview. After a 2-week consideration period, the client was phoned to request consent for participation. Nonparticipation had no consequences for the care that they received. Interviews were held at a location of the participant's choice (home or F-ACT office), and were carried out by trained interviewers who all had working experience with the target population. Before the interview took place, written consent was requested. The interviews lasted on average 75 min. Afterward, the client received a financial compensation of €5, €10, and €15 for T0 (baseline), T1 (after 10 months), and T2 (after 20 months), respectively. In total, 409 baseline interviews were conducted, of which 9 were excluded due to unreliable answers, as indicated by the interviewers

(Figure 1). A response rate of almost 30% was achieved and the overall dropout rate was 17%.

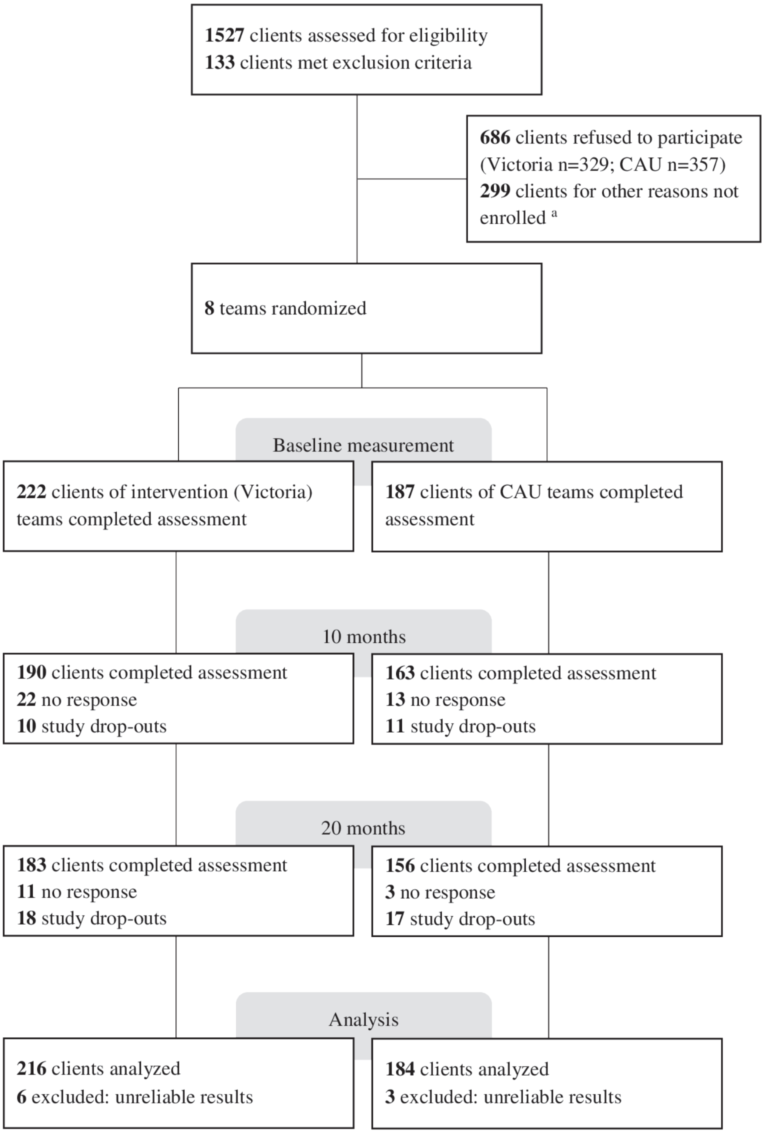

Figure 1. Flow of participants through the study
Note. CAU = Care as usual
[a] other reasons why they were not enrolled were: i) it was impossible to reach/contact some of them, ii) some were excluded during the 6-month inclusion period due to longer admission in a (psychiatric) hospital and symptoms too severe to complete the interview, iii) they passed away, iv) did not show up for their appointment, or v) withdrew during the first interview session.

Measures

Primary outcomes

Social participation was assessed with the Social Functioning Scale by Birchwood et al. [32], and includes: social engagement/withdrawal, interpersonal behavior, prosocial activities, recreation, independence-competence, independence-performance, and employment or occupation. The scale showed good reliability (α = .80) and the item-total correlation was (*r* = .71). A sum score of the seven subscales was included in the analyses.

In addition, the mental health professional assessed whether their client was avoiding or stagnating in social participation, on a scale ranging from 0 = *not at all* to 3 = *yes, definitely*.

Victimization was measured using the Dutch Safety Monitor [33]. Statistics Netherlands regularly uses the Dutch Safety Monitor to measure victimization and neighborhood satisfaction among the general Dutch population. Although the Safety Monitor has been used in mental health care studies [6], psychometrics are not available because the survey is updated yearly for annual monitoring. We included 12 crime incidents in the analyses, as follows: property victimization (home burglary, bicycle theft, (attempted) robbery, and other theft), personal victimization (sexual intimidation or assault, threats (of violence), and physical assault), digital victimization (identity fraud, hacking, and cyberbullying), and others (vandalism and fraud with buying/selling items/services). Car and motor theft items were excluded, because few of the participants owned such a vehicle. Each incident that occurred in the previous year was added up, using 1 = *yes* or 0 = *no*. Polyvictimization was also included in the analyses and was defined as experiencing four or more different types of victimization in the previous year [34]. In addition, general perceived unsafety was included from the Dutch Safety Monitor, which is measured dichotomously.

Discrimination and stigma experiences were measured using the Discrimination and Stigma Scale (DISC-12) [35] which consists of four subscales. Three subscales were used in this study, but the fourth subscale had many missing values and was generally poorly understood. The 'unfair treatment' subscale (experienced discrimination) consisted of 22 items, the 'stopping self' subscale (anticipated discrimination) contained four items, and the 'overcoming stigma' subscale contained two items. All subscales were ranked from (0) '*no difference*' to (3) '*a lot*'. Reliability was good (overall α = .78; subscales ranged from α = .82 to α = .66). For each subscale, all of the scores were summed and a mean score was included in the analyses.

Secondary outcome measures

Acknowledgement of difficulties and support in recovery was measured by asking questions about whether the client felt positive and hopeful after conversations with their professional about difficulties with participation, for example, “After discussing these experiences, I feel heard, I feel relieved, discussing difficulties ensures making steps in my recovery process.” A factor analysis showed a factor comprising of six questions with factor loadings from .73 to .84, with a high reliability (α = .90). A mean score is included.

Self-efficacy in mental-health-related beliefs and empowerment was measured using the sum score of the Mental Health Confidence Scale (MHCS) [36], which uses a 6-point Likert scale and showed good reliability (α = .93).

Quality of life was measured using the Manchester Short Assessment of Quality of Life (MANSA) [37]. The MANSA comprises 16 questions of which 12 questions are scored on a 7-point Likert scale ranging from “could not be worse” to “could not be better.” A mean score of the 12 items was used. The reliability of the scale was high (α = .81) [38].

Psychosocial functioning was calculated using the Health of the Nation Outcome Scales (HoNOS) [39]. This is a frequently used 12-item scale on which the professional scores the client’s general psychosocial functioning on a continuum ranging from 0 = *no problems* to 4 = *a lot of problems*. Psychometrics were shown to be good (intraclass correlation coefficient = .92, α = .78) [40].

Additional and control measures included sociodemographic characteristics (age, gender, living situation, education, being born in the Netherlands, marital status, and income), client characteristics (primary DSM-IV diagnosis and any substance use disorder [DSM-IV]), social support, perpetration, neighborhood characteristics (social cohesion, nuisance, and unsafety), and team characteristics. Social support was measured using the sum score of the 11-item Inventory of Social Reliance (ISR) [41]. Primary diagnosis was collected at baseline measurement from the electronic client record. Similar to victimization, perpetration and neighborhood characteristics were assessed with the Dutch Safety Monitor. For team characteristics, the overall fidelity scores and specific rehabilitation items of the official F-ACT audits were used. An overall score of 0–3 is considered insufficient, 3.1–3.3 is an average implementation, 3.4–4.0 is a sufficient/good implementation, and >4.1 is an excellent implementation.

Statistical methods

We performed a sample size calculation for the Social Functioning Scale, because this is the primary outcome for which effect sizes were known [42]. We adopted a frequently used formula that is suitable for cluster randomization and measurements over time [43]. This was calculated with the ratio of the number of subjects in the compared groups being 1 (r), a correlation coefficient of the repeated measurements of .20 (ρ), and a conservative difference between the groups in the mean value of social functioning of .25 (v). In total, 151 respondents were needed in each arm at T2 measurement to attain a power of .80 [18]. With *n* = 183 in the experimental condition and *n* = 156 in the control condition at T2 measurement, there was sufficient power to detect an effect size at the level of $p \leq .05$.

Data were analyzed according to intention to treat. All analyses were two-sided tests, with $p \leq .05$ indicating statistical significance. To account for multiple comparisons and avoid Type I errors, the Benjamini–Hochberg procedure was applied [44]. Client characteristics were calculated for both the intervention group and the control group. Significant differences at baseline were included as covariates in the later analyses. Sociodemographic and other client characteristics were analyzed in a separate regression analysis with a backward elimination procedure to establish which variables were significant predictors of primary and secondary outcomes. They were then added as covariates in the analyses. When both primary diagnosis and substance use disorder were significant predictors, only the primary diagnosis was included. Similarly, if multiple perpetration items were predictors, then only total perpetration was included.

For the main analyses, we used linear mixed models (LMMs) with group allocation and time as independent variables, and only random intercepts for respondents due to convergence issues. Given that an LMM is robust in handling missing data [45], multiple imputation was unnecessary. For the continuous outcome variables, we estimated linear regression models. For the dichotomous and count outcome variables, we computed logistic regression models using generalized estimating equations (GEEs) [46] because it is more robust at estimating effects in dichotomous variables than generalized LMMs [47]. Time (measurement) was included as a categorical variable. All of the continuous independent variables were mean centered to reduce problems with multicollinearity. We used SPSS version 24 for the descriptive analyses, and we used R version 3.5.2 for the LMM and GEE analyses. In R, packages lme4 version 1.1-21 [48], lmerTest version 3.1-0 [49], and geepack version 1.2-1 [50] were used.

Results

Client and team variables

Analyses at baseline on age, gender, mental health care center, and F-ACT team in the nonresponders versus the responders showed no significant differences. At baseline, four characteristics differed across the intervention and control groups: People in the control group were older, were more frequently born in the Netherlands, had fewer substance use disorders, and had experienced less neighborhood nuisance. These characteristics were adjusted for in the analyses. The overall F-ACT fidelity team score before baseline measurement was 3.9, and ranged from 3.6 to 4.3 (Table 1). All scores on the rehabilitation items were lower than the mean team score.

Primary outcomes

Table 2 shows the observed mean scores and Cohen's *d* of the primary and secondary outcomes in the intervention and control groups. In total, 18.8% of all participants had experienced one or more property crime incidents in the previous year (i.e., 12 months before baseline measurement), which was lower than prevalence rates found in a large Dutch study in a representative sample of clients with SMI [6]. However, we found higher prevalence rates for personal crime and total victimization: 21.3% and 46.1%, respectively. On T1, personal victimization slightly significantly increased in both conditions, but this difference disappeared at T2.

The time, condition, and interaction effects of continuous variables are shown in Table 3. Experienced discrimination increased in both conditions over time. However, by T2, an interaction is evident with the intervention condition; in the intervention group, the initial increase diminishes, whereas the control condition shows an even steeper increase in experienced discrimination over time. Moreover, the overall interaction effect was also significant for experienced discrimination, *F*(2, 659) = 4.43, *p* = .01 (S1 Table). In addition, both conditions showed an increase in anticipated discrimination over time. When corrected for multiple comparisons, no intervention effect was found. For social functioning, we found no significant differences between the groups over time [*B* = –5.17, *t*(635) = −.96, *p* = .51]. The same holds true for overcoming stigmatization [*B* = −.04, *t*(698) = −.34, *p* = .74], avoiding social participation (*OR* = 1.67; 95% CI = .95, 2.93; *p* = .15), stagnation in participation (*OR* = 1.38; 95% CI = .76, 2.5; *p* = .56), victimization (*OR* = .95; 95% CI = -.40, .29; *p* = .90), and perceived unsafety (*OR* = .71; 95% CI = .40, 1.26; *p* = .48).

Secondary outcomes

We found a time by condition effect where the intervention group over time reported increased acknowledgment and support in recovery at T2, while the control group showed a decrease over time. In addition, the clients' self-efficacy improved at T1 and T2, but we found no significant interaction effect. Finally, we found no significant effects for the clients' quality of life [*B* = .00, *t*(754) = .00, *p* = .99] and psychosocial functioning [*B* = .18, *t*(604) = .27, *p* = .95].

Table 2. *Means and descriptive statistics of primary and secondary outcomes at baseline, 10, and 20 months*

	T0				T1				T2			
	Intervention (n = 216)		Control (n = 184)		Intervention (n = 190)		Control (n = 162)		Intervention (n = 181)		Control (n = 151)	
Primary outcomes												
Social functioning, *M* (*SD*)												
Engagement	102.44	(11.77)	103.18	(11.46)	102.84	(11.43)	102.54	(9.85)	101.67	(9.73)	102.49	(10.30)
Interpersonal	118.53	(19.49)	118.64	(18.45)	121.05	(20.41)	122.04	(18.84)	119.82	(19.72)	119.17	(18.41)
Independence - performance	110.39	(9.24)	108.87	(9.83)	110.83	(10.03)	109.80	(10.05)	110.36	(9.62)	110.00	(10.13)
Recreation	114.28	(17.45)	114.46	(14.52)	114.68	(18.05)	113.68	(15.79)	115.16	(17.45)	113.11	(16.89)
Pro-social	104.78	(14.89)	105.49	(14.70)	105.20	(14.60)	105.44	(15.14)	104.71	(14.81)	105.89	(13.73)
Independence - competence	107.82	(9.51)	106.88	(9.95)	107.55	(10.83)	106.71	(10.72)	109.23	(10.52)	106.58	(11.24)
Occupational	102.73	(15.27)	102.30	(15.52)	105.29	(14.66)	102.50	(16.23)	102.60	(15.19)	103.06	(15.20)
Total social functioning [a]	757.59	(70.75)	755.21	(68.91)	765.17	(69.58)	760.18	(66.23)	758.15	(73.78)	758.84	(64.31)
Avoiding social participation, no. (%)	85	(41.26)	72	(40.68)	69	(43.67)	55	(38.46)	69	(45.70)	50	(36.50)
Stagnation in social participation, no. (%)	90	(44.55)	68	(40.00)	68	(44.16)	56	(39.72)	68	(46.26)	51	(37.23)
Victimization												
Property victimization, *M* (*SD*)	0.28	(0.57)	0.17	(0.45)	0.24	(0.54)	0.17	(0.42)	w0.29	(0.60)	0.22	(0.47)
Personal victimization, *M* (*SD*)	0.28	(0.57)	0.27	(0.58)	0.39	(0.66)	0.24	(0.50)	0.33	(0.67)	0.29	(0.61)
Digital victimization, *M* (*SD*)	0.21	(0.49)	0.15	(0.42)	0.14	(0.44)	0.13	(0.37)	0.18	(0.44)	0.19	(0.52)
Polyvictimization, no. (%)	14	(6.48)	6	(3.26)	11	(5.79)	4	(2.47)	12	(6.63)	6	(3.97)

Table 2. *Continued*

	T0				T1				T2			
	Intervention (n = 216)		**Control (n = 184)**		**Intervention (n = 190)**		**Control (n = 162)**		**Intervention (n = 181)**		**Control (n = 151)**	
Total victimization, *M* (*SD*) [b]	0.95	(1.33)	0.78	(1.14)	0.90	(1.34)	0.70	(1.00)	0.99	(1.47)	0.85	(1.30)
Perceived unsafety, no. (%)	115	(54.76)	89	(49.17)	93	(49.21)	75	(46.30)	83	(46.37)	76	(51.35)
Discrimination and stigmatization (DISC-12), *M* (*SD*)												
Experienced discrimination [c]	0.46	(0.44)	0.39	(0.42)	0.50	(0.54)	0.44	(0.49)	0.48	(0.50)	0.55	(0.59)
Anticipated discrimination [d]	0.80	(0.82)	0.83	(0.82)	1.00	(0.90)	0.93	(0.90)	1.13	(0.95)	0.91	(0.88)
Overcoming stigmatization [d]	1.20	(0.98)	1.16	(1.00)	1.36	(1.01)	1.23	(1.03)	1.21	(1.04)	1.22	(1.06)
Secondary outcomes												
Acknowledgement of difficulties, *M* (*SD*) [e]	2.75	(0.68)	2.85	(0.76)	2.82	(0.69)	2.86	(0.71)	2.79	(0.62)	2.68	(0.72)
Self-efficacy (MHCS), sum (*SD*) [f]	65.34	(14.43)	66.97	(11.79)	67.27	(14.15)	68.99	(12.31)	67.40	(13.68)	67.68	(13.35)
Quality of life (MANSA), *M* (*SD*) [g]	4.41	(0.93)	4.61	(0.84)	4.48	(0.93)	5.25	(7.25)	4.57	(0.97)	4.71	(0.96)
Psychosocial functioning (HoNOS), sum (*SD*) [h]	11.15	(5.72)	10.33	(5.98)	10.19	(5.11)	9.63	(5.50)	10.83	(5.30)	10.06	(6.19)

Note. T0 = baseline measurement, T1 = 10 month follow-up, T2 = 20 month follow-up.
[a] minimum = 479.5, maximum = 911.5; [b] minimum = 0, maximum = 7; [c] minimum = 0, maximum = 2; [d] minimum = 0, maximum = 3; [e] minimum = 0, maximum = 4; [f] minimum = 24, maximum = 96; [g] minimum = 1.75, maximum = 6.55; [h] minimum = 0, maximum = 3

Table 3. *Linear mixed models of the effect of the intervention on primary and secondary outcomes*

				95% CI	
	Estimate	SE	B-H corrected p value	Lower	Upper
Primary outcome					
Social functioning			ns		
Experienced discrimination [a]					
T1	.071	.024	.003	.024	.118
T2	.110	.025	<.001	.062	.158
Intervention group	.0006	.039	.987	-.074	.075
T1 × group	-.017	.048	.717	-.111	.075
T2 × group	-.135	.049	.011	-.230	-.040
Anticipated discrimination [b]					
T1	.146	.055	.008	.038	.253
T2	.209	.056	<.001	.099	.318
Intervention group	.039	.066	.555	-.089	.167
T1 × group	.072	.109	.512	-.142	.286
T2 × group	.240	.112	.063	.023	.459
Overcoming stigmatization			ns		
Secondary outcome					
Acknowledgement of difficulties [c]					
T1	.015	.042	.712	-.066	.097
T2	-.079	.042	.123	-.161	.003
Intervention group	-.009	.055	.871	-.114	.097
T1 × group	.042	.083	.609	-.119	.203
T2 × group	.187	.083	.050	.024	.349
Self-efficacy (MHCS) [d]					
T1	1.446	.582	.026	.308	2.580
T2	1.215	.601	.044	.039	2.386
Intervention group	-.799	1.057	.450	-2.842	1.246
T1 × group	-.694	1.159	.549	-2.959	1.562
T2 × group	1.325	1.185	.528	-.992	3.631

Table 3. *Continued*

	Estimate	SE	B-H corrected p value	95% CI Lower	95% CI Upper
Quality of life (MANSA)			ns		
Psychosocial functioning (HoNOS)			ns		

Note. B-H = corrected *p* value according to the Benjamini-Hochberg procedure; T1 = 10 month follow-up, T2 = 20 month follow-up; ns = not significant; all models are corrected for age, born in the Netherlands, living situation, SUD, and neighborhood nuisance.

[a] Controlled for gender, education, diagnosis, perceived unsafety of neighborhood, and personal perpetration; [b] controlled for marital status, and neighborhood cohesion; [c] controlled for employment status, diagnosis, social support, and property perpetration; [d] controlled for diagnosis, social support, and perceived unsafety of neighborhood.

Discussion

We evaluated the effects of the Victoria intervention on social participation, criminal victimization, and (anticipated) discrimination through a multicenter cluster randomized controlled trial. No effects on social participation and victimization were found. However, we found an increase in both groups in terms of experienced discrimination, anticipated discrimination, and self-efficacy. Even though these effects were small, in the last follow-up measurement having Victoria conversations has a moderating effect on the found increase in experienced discrimination, and the clients felt significantly more acknowledged and supported in their recovery process. We found no significant effects for the other secondary outcomes.

The intervention's lack of effect on social participation might be related to the findings from our previous study, which indicate that high scores on social functioning and high scores on victimization can go hand in hand [51]. Therefore, the future studies of victimization could investigate how much the clients actually benefit from their social network, or could examine the protecting factors for victimization. In addition, we found low scores on rehabilitation items in participating teams [52]. Given that our intervention is intertwined with rehabilitation, effects can be more difficult to achieve.

The lack of an intervention effect on victimization might have a methodological explanation. In contrast to experienced discrimination, which is often experienced on a daily basis, criminal victimization is often highly skewed toward the zero. This increases the difficulty to measure change due to our intervention. Future research should specifically examine clients that were victimized or who benefited from the Victoria intervention.

Even though experienced discrimination increased in both conditions, we found a moderating effect of the intervention. Future studies should examine whether the intervention supports clients becoming more resilient to discrimination. Previous studies showed that educational interventions are effective in reducing mental health-related stigma and discrimination [53]. This study adheres to this view with these tentative results from a pragmatic trial.

The overall increase found in experienced and anticipated discrimination might be related to an increase in awareness of the negative stereotypes in both groups, due to the fact that both the intervention and control teams were aware that they had participated in research on victimization and the clients in both groups might have had more conversations on victimization than they did before the study. Therefore, a longer follow-up of our sample might be useful, to examine whether discrimination decreases after an initial increase.

Even though the Victoria intervention was developed to be easy to use and the training was completed with intervision sessions, and the participating professionals were enthusiastic and actively involved in both the development of the intervention and the trial, in practice this intervention still was difficult to implement. We think this problem may be related to the required change in the professional's attitudes and a lack of knowledge because victimization and trauma were not previously discussed with persons with SMI on a structural basis [1,15]. We assume that with time, victimization sensitive interventions will receive increasing attention, as trauma sensitive interventions did in the last few years[54]. This study's implementation rate also suggests that a more integrated approach is necessary. This entails a victimization-informed approach, from intake throughout further treatment [4]. In addition, to get a better idea of the implementation process, a process evaluation including qualitative data was performed and publication of these data is planned.

Although some studies state that a professional should not discuss victimization experiences without (trauma) treatment [55], our results refute these hesitations. There was no increase in victimization or perceived unsafety, no decrease of quality of life, and no decrease in social functioning in the intervention group.

Our study provided first indications that by addressing victimization, the clients feel acknowledged and supported in encountering future social situations. Acknowledging pain and loss and allowing the client to develop a broader narrative are important parts of the recovery process [56]. Combining the predominant problem-oriented perspective that is often present in outpatient teams and a recovery-oriented method such as the

Victoria intervention remains difficult and is often a source of friction. Consequently, a balance between taking responsible risks, and safety and security, is necessary if we want to truly practice recovery-oriented care [27].

Strengths and limitations

One of the main strengths of this study is the large sample size and the accompanying statistical power of the results, especially when given that it is often difficult to include clients with SMI in longitudinal studies. Other strengths include the wide variety of outcome measures (making it possible to examine diverse time effects of the intervention), the inclusive recruitment of clients (which simulates the real-life setting of community treatment teams), and the multicenter design of this study.

This study also experienced some limitations. First, it takes time to measure the effect of a behavior change, which occurs as a result of an attitude change [57]. Consequently, a 20-month follow-up period might be too short and implementation in a study setting too sparse. Therefore, we recommend that future research should follow-up on clients for 5 years or even longer to examine the effects of a victimization-focused intervention. Second, there is also the possibility of selection bias due to the response rate, even though similar response and dropout rates were found in other studies in outpatient groups [6,58]. However, to overcome this potential pitfall, we did a nonresponse analysis, and we compared our sample with other studies. Clients in our sample scored comparably to other groups of clients with SMI on psychosocial functioning [40], primary diagnosis [20], and self-efficacy [29]. Third, our researchers and professionals were not blinded for assignment to the experimental condition, which may bias the results given that the professionals were asked to fill out a questionnaire on their clients. Fourth, because the Victoria intervention is a new intervention, fidelity measures were not available or yet developed. However, to approach fidelity and get insight into the implementation, we included F-ACT fidelity measures for both conditions in the analysis, trained both conditions in BPR, and we examined implementation experiences in a process evaluation. Fifth, we were unable to provide the number and range of the intervention sessions, which complicates drawing conclusions about the dose of intervention. Due to the individualized character of the intervention, the number and length of the sessions vary. In addition, it was undoable to register several conversations of the 222 clients in intervention teams. To enhance interpretation of the RCT results, we performed a process evaluation in which we observed supervision meetings, held qualitative interviews with trainers, professionals, and clients, to examine which factors influenced the implementation, and capture the professionals' and the clients' experiences with and perceptions of the intervention. Results of this process evaluation are yet to be published. Finally, we only executed power calculations on one of the primary outcome measures (i.e., social functioning) and not on the other primary and secondary outcome measures. This may lead to Type I errors or a wrong conclusion on the required sample size, which is why we applied the Benjamini–Hochberg procedure [44]. We have also used a conservative estimation on change in social functioning in the sample size calculation [42].

Conclusions

This is the first (pragmatic) randomized controlled trial to examine the effects of an intervention that explores and analyzes the victimization experiences of people with SMI in relation with their social participation. The Victoria intervention had no effects on victimization and societal participation. However, there were indications that the intervention was successful in moderating experienced discrimination. Small but significant effects were also found on the feelings of acknowledgment and recovery support. These findings may reduce the reluctance to discuss victimization experience that hampers the client's social participation. Further development of the intervention is needed, and future research should focus on improving implementation.

Appendix

S1 Table. Overall interaction effects for time and condition for GEE and LMM models of primary outcomes

	χ^2	*p* value
Primary outcomes		
Avoiding social participation	33.763	.185
Stagnation in social participation	11.283	.569
Property victimization	1.287	.526
Personal victimization	6.332	.042
Digital victimization	2.149	.341
Poly-victimization, no. (%)	.682	.711
Total victimization	.220	.896
Perceived unsafety, no. (%)	1.397	.497
	***F* value**	***p* value**
Social functioning	.486	.615
Experienced discrimination	44.312	.012
Anticipated stigmatization	24.013	.091
Overcoming stigmatization	.290	.749
Secondary outcomes		
Acknowledgement of difficulties	26.943	.068
Self-efficacy (MHCS), sum (*SD*)	14.420	.237
Quality of life (MANSA), *M* (*SD*)	11.871	.306
Psychosocial functioning (HoNOS), sum (*SD*)	.057	.944

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6

Addressing victimization to enable societal participation in flexible assertive community treatment

A process evaluation of the implementation of a new intervention

Published as:
Albers WMM, Nijssen YAM, Roeg DPK, van Weeghel J, Bongers IMB. Addressing victimization to enable societal participation in flexible assertive community treatment: A process evaluation of the implementation of a new intervention.

Front Psychiatry. 2022;13:956133.

Abstract

Background
Individuals with severe mental illness experience more victimization and discrimination than other persons in the community. Effective rehabilitation and recovery-oriented care interventions aimed at addressing this issue are lacking. We therefore developed a victimization-informed intervention (accompanied by a training module for professionals) called *the Victoria intervention*. The purpose of the present study was to understand the trial effects by examining the implementation process and the factors that influenced it.

Methods
A process evaluation was conducted using a mixed-methods design. During the professionals’ intervision sessions, we used observations to understand the learning processes (n = 25). Subsequently, we studied the use of the intervention in practice through structured questionnaires (n = 215) and semi-structured interviews (n = 34) with clients and professionals. We used descriptive and inferential statistics for the quantitative data and the framework method for the analyses of the qualitative data.

Results
The observations showed that the trainings were well received. The professionals shared the urgency of paying attention to victimization and discrimination and its harmful effects on participation. They also found the intervention steps to be logical and the intervention protocol easy to use. Nevertheless, they mentioned in the interviews that they had experienced difficulties initiating a conversation about victimization, and if they started one, they did not always follow the steps of the intervention as intended. Few clients said that victimization was placed on the agenda, though those who had discussed victimization with their caregivers expressed their appreciation in the interviews; they felt acknowledged and supported.

Discussion
The findings indicate that the intervention was considered helpful in raising awareness and the acknowledgment of victimization. However, professionals remain reluctant to talk about the subject, and the results show they need more practical training in this regard. This process evaluation has an important added value in that it helps us to understand the results of the effect evaluation of the intervention. The findings will facilitate the development and implementation of interventions that address clients’ victimization experiences in community mental health care settings and subsequently enable their participation in society.

Contribution to the Field Statement

Although individuals with severe mental illness are more often victimized and discriminated against than other persons in the community, effective tools aimed at addressing their adverse experiences are lacking. We developed an intervention for professionals in community mental health care teams to help them address their clients' victimization and enable their societal participation. The present study examines the use of the intervention, the factors that influenced it, and the perceived benefits for clients. The results suggest that the intervention increased the parties' awareness of victimization. Even though the steps in the intervention were not always followed, professionals responded positively. It gave them greater insight into their clients' rehabilitation wishes and presented the opportunity to discuss their victimization experiences.

Keywords

Victimization, participation, stigma and discrimination, severe mental illness, mixed-methods design, process evaluation, rehabilitation, recovery-oriented care

Introduction

Individuals with severe mental illness (SMI) are victims of crime and discrimination more often than other citizens [1-5]. The consequences of victimization, discrimination, and stigmatization can worsen symptoms and additional mental health issues, re-victimization, perpetration, and social isolation [1,6,7], which are considered important barriers to societal participation and recovery [6,8,9]. While evidence exists that understanding and addressing why a client is demoralized by previous victimization experiences are beneficial for rehabilitation and recovery [10-14], effective tools to recognize and address victimization experiences, including (anticipated) stigmatization and discrimination, are lacking. We developed and tested the Victoria intervention, a four-step intervention that aims to increase safe societal participation by increasing awareness and the acknowledgment of victimization [15]. The effect study was published in a previous article [16].

Several characteristics of the Victoria intervention, the trial, and the results made it important to carry out a process evaluation. First, we wanted to understand the trial effects as we performed a cluster randomized controlled trial (RCT) with the intervention in flexible assertive community treatment (FACT) teams [17,18]. Although we found that the intervention successfully moderated experienced discrimination, it had no effects on participation and victimization or on other primary outcome measures, contrary to our expectations [16]. Nevertheless, clients felt that their victimization experiences were acknowledged and that they were supported in the recovery process. In both the intervention and control groups, anticipated discrimination and self-efficacy increased slightly over time. However, even though previous studies have reported that participants feared relapse after discussing their victimization experiences [19,20], psychosocial functioning, victimization, and other outcomes neither worsened nor increased in the intervention group. Conducting a process evaluation was warranted to help understand these mixed findings and move forward with the intervention in practice [21,22].

Second, the design of the Victoria intervention makes it difficult to measure its use in daily practice. It trains professionals to discuss victimization experiences with their clients, and we expect clients to feel acknowledged and supported in their recovery process (i.e., for the intervention to have an indirect effect). What happens in the process is not easy to quantify in an effect evaluation. The degree of flexibility that is built into the intervention adds to this complexity. By executing a process evaluation, we can obtain knowledge about the extent to which professionals recognize and acknowledge victimization in their clients [22,23].

Third, practical trials, such as the one in which the Victoria intervention was tested, are characterized by multiple interacting components, and the context, which may partially determine the outcome is difficult to control for [24]. For example, we trained the professionals in the FACT teams and we measured the effects for 20 months. In this timeframe, we could not rule out any change of personnel or conversations between teams. Furthermore, the trial was performed in multiple sites, each of which had specific contexts that may have influenced outcomes [25]. In these complex settings, whether the intervention works is naturally important, but contextual influences on implementation or outcomes also have to be examined to gain deeper insights [21,25]. Gathering the perspectives of all stakeholders can provide knowledge of these contextual effects. Moreover, process evaluations can help us understand why certain effects are obtained by measuring the response of the intervention among clients and professionals [23,25].

Hence, by examining the implementation process (including training and use), the factors that influenced it, and the impact the intervention had on the clients, we aimed to understand the trial effects.

Materials and methods

Design

For this process evaluation, which was embedded in a previously published cluster RCT [26], we used a mixed-method design using both qualitative and quantitative data (see Table 1 for the research questions and accompanying data sources). First, as the intervention was interwoven in the rehabilitation work of the FACT team, treatment plans for clients from both the intervention and control groups were used to measure adherence to rehabilitation principles in general. Second, the intervision sessions (i.e., meetings coached by a trainer to discuss the conversations they have had in their daily work) following the training were audio-recorded so we could assess the extent to which the professionals used the intervention in daily practice, how and when they used it, and the factors that influenced its use. Third, for the quantitative part of this study, data from structured questionnaires among clients and professionals were analyzed to examine perceptions of clients' conversations with their case managers and whether the professionals concerned were aware of their clients' victimization experiences. Fourth, the professionals were asked to fill out a checklist during the intervision sessions to see how faithful they had been to the intervention itself. The checklist was designed in the development phase of the intervention. Finally, semi-structured interviews were conducted with professionals of the intervention teams, management, and trainers to gather information about their experiences of the training sessions, influences on the use of the intervention, how and when they used the intervention, and the impact of the intervention on the client from the perspective of the professional. Semi-structured interviews were held with clients to cross-check the use and impact of the intervention. The study protocol of the RCT was approved by the Medical Ethical Committee of the Elisabeth Hospital in Tilburg (NL53845.028.15) on 18 November 2015 for all participating sites. The study was registered with the Dutch Trial Register (NTR 5585).

Table 1. Research questions and relevant data sources

		Treatment plans	Observations of intervision meetings	Structured questionnaires (professionals)	Structured questionnaires clients	Checklist (professionals)	Interviews with professionals	Interviews with clients
Rehabilitation principles	To what extent do professionals work according to rehabilitation principles?	x						
Training	What were the experiences with training and intervision meetings?						x	
Use	To what extent did the professionals use the intervention?		x	x		x	x	x
	How did they apply the intervention?		x				x	
	When did they apply the intervention?		x				x	
	What factors influenced the use of the intervention?		x				x	
	What was the perceived impact of the intervention on clients?		x		x		x	x

The intervention

The Victoria intervention was designed to be victimization informed and to serve as an add-on module so that professionals can be made aware of and sensitive to the topic while employing rehabilitation approaches. It supports professionals in starting and structuring conversations with their clients regarding their experience of victimization and how it impacts their societal participation. The intervention comprises four steps: exploration, analysis, clarifying the context, and future strategies [15]. The first step involves exploring the client's societal participation and their satisfaction with it. When a client is avoiding societal participation or if their desired progress is stagnating, continuing to the second step is indicated. During the second step, relevant negative experiences related to societal participation are discussed. A narrative approach is adopted in which the professional acknowledges the pain of the client's victimization experiences [27] and tries to understand the avoidance or stagnation. The third step is to clarify the context of the experience, that is, why the client initially engaged with the situation in which they were victimized. The objective of this step is to switch from the negative experience to a more positive perspective as taking reasonable risks is necessary to progress in life. The fourth step is to conclude the conversation by determining future steps. This can vary from planning another conversation, reformulating a rehabilitation action plan, starting other interventions such as supported employment (e.g., IPS) or treatment for self-stigma (e.g., NECT), or, when there is underlying trauma, trauma-focused therapy.

Training consisted of a refresher on the rehabilitation method that had been used previously. This was followed by three sessions on the Victoria intervention for the entire team. The first session comprised securing the intervention on an individual and team level. The second and third sessions were provided as per the respective organizations. In the first session, ways were discussed to implement and secure the intervention as part of the participants' daily routine. The second and third sessions comprised an explanation of the steps and role-playing practice. Finally, intervision meetings were held every six to eight weeks. During these, the conversations the professionals had been having with their clients were discussed (with the assistance of a trainer). A short handout was designed to be used during conversations with clients.

Participants

The participants comprised mental health nurses, experts-by-experience, managers, and clients of eight FACT teams. The trainers were also invited to take part in qualitative interviews. For an overview of all participants and other data sources, see Table 2.

Table 3 lists the characteristics of the study participants in both the subsample for the qualitative interviews, as well as the full sample from the structured interviews from the RCT. In the subsample, half of the client participants were males, and the average age of the clients was 45. Most of the clients had a psychotic or mood disorder as a primary diagnosis. In the full sample, most had schizophrenia; 56.2% of the clients had been the victims of one or more incidents of crime in the previous year, and 46.1% of the clients in the RCT sample. Ten of the professionals were male and eight, female.

Table 2. Data sources included in the analyses

Data source	***N***	**Average duration**[a]
Treatment plans	66	-
Observations		
Intervision meetings	25	50
Structured questionnaires		
Clients and professionals	215	-
Checklists	20	-
Qualitative interviews (*n* = 34)		
Clients	16	28
Mental health nurses	7	39
Experts-by-experience	5	39
Managers (of which one was also a psychiatrist)	3	37
Trainers	3	48

Note. [a] Time is in minutes

Table 3. Characteristics of the interviewees at T2

	Subsample (*n* = 16)	**Full sample (*n* = 332)**
Clients		
Gender		
Male	8 (50%)	199 (59.9%)
Female	8 (50%)	133 (40.1%)
Age at beginning of the study		
<30	-	12 (3.6%)
30-39	5 (31.3%)	63 (19%)
40-49	5 (31.3%)	117 (35.2%)
50-59	6 (37.5%)	106 (31.9%)
>60	-	34 (10.2%)

Table 3. *Continued*

	Subsample (*n* = 16)	**Full sample (*n* = 332)**
Education		
Low	7 (43.8%)	160 (48.8%)
Middle	5 (31.3%)	125 (38.1%)
High	2 (12.5%)	43 (13.1%)
Living situation		
Living at parents	-	7 (2.1%)
Supported housing	-	38 (11.6%)
Living on their own	16 (100%)	283 (86%)
Other	-	1 (0.3%)
Born in the Netherlands		
Yes	13 (81.3%)	287 (86.4%)
No	3 (18.8%)	45 (13.6%)
Marital status		
Not married	8 (50%)	218 (65.9%)
Divorced	4 (25%)	58 (17.5%)
Married	4 (25%)	45 (13.6%)
Widow/widower	-	8 (2.4%)
Living together	-	2 (0.6%)
Employment status		
Benefits	15 (93.8%)	249 (75%)
State pension	-	3 (0.9%)
Employed	1 (6.3%)	62 (18.7%)
Other	-	18 (5.4%)
Primary diagnosis on T0		
Schizophrenia	1 (6.3%)	114 (28.4%)
Other psychotic disorder	6 (37.5%)	99 (24.7%)
Mood disorder	4 (25%)	49 (12.2%)
Anxiety disorder	1 (6.3%)	27 (6.7%)
Developmental disorder	1 (6.3%)	38 (9.5%)

Table 3. *Continued*

	Subsample (*n* = 16)	Full sample (*n* = 332)
Substance use disorder	-	5 (1.2%)
Other diagnosis on AxI	1 (6.3%)	13 (3.2%)
Personality disorder	2 (12.5%)	56 (14%)
Professionals (*n* = 18)		
Role		
Mental health nurses (case manager)	7 (38.9%)	-
Experts-by-experience	5 (27.8%)	-
Managers (of which one is also a psychiatrist)	3 (16.7%)	-
Trainers	3 (16.7%)	-
Gender		
Male	10 (55.6%)	-
Female	8 (44.4%)	-

Procedure

All qualitative interviews were conducted between April and July 2018, during the 20-month follow-up period of the RCT. For the professionals, a purposive sample per team of three mental health professionals, including one expert-by-experience, was recruited to reflect a diverse range of opinions on the intervention. As the number of trainers and managers was limited, all were asked to participate, and all agreed.

From the clients who participated in the RCT and were exposed to the intervention at the request of their case manager, a random sample of 24 was contacted via telephone for a qualitative interview, and 16 agreed to participate. We based the number of clients needed to contact on several factors, such as the research questions, the nature of the interview topics (questions were rather specific), the use of other data (i.e., triangulation), and practicality [28,29]. Additionally, by taking into account a 15% attrition rate, we invited one extra client per intervention team. Non-participation had no consequences in terms of the care they received. The interviews were held at a location of the participant's choosing (i.e., either home or FACT team office). Before the interviews took place, written consent was requested. The interviews with both the professionals and clients were led by an interview guide. Topics were based on the intervention components [15] and a framework for process evaluations for cluster RCTs [25]. Since we wanted to elicit specific information from each of the groups, different interview guides were developed for each group (see Appendix X). The guide for the professionals included their perspectives on the intervention, their ideas regarding its usability and degree of usage, and their ideas on clients' experience of the intervention. For the clients, the guide included their experience of conversations (with their case manager) and their difficulties with societal participation and victimization.

To ensure their objectivity, the interviews were carried out by two research assistants who were not involved in the development of or training in the intervention. They had training in interviewing and discussed issues that emerged after the first interviews. The interviews were audio-recorded unless otherwise requested by the participant, and were pseudonymized. On average, the interviews with the professionals lasted 40 minutes, and with the clients, 28 minutes (see Table 1). The clients received financial remuneration of €10.

The structured questionnaires were collected during the effect evaluation within the RCT at T1 (10-month follow-up) and T2 (20-month follow-up). The professionals' questions addressed the extent to which they had used the intervention in daily practice with each of the clients in the study and the insight gained into how victimization acted as a barrier to clients' societal participation. The clients' questions addressed the extent to which they felt they were being listened to and supported in their recovery process.

The intervention teams had on average 7-9 intervision meetings. Eighty percent (25 out of 31) of the intervision meetings were audio recorded (six were missing, for practical reasons unrelated to the study questions). A trainer, professionals from the intervention team, and a researcher participated in each meeting.

Pseudonymized treatment plans from a random sample of 15% of the clients participating in the RCT were collected at T0 (baseline) and T2, resulting in 63 treatment plans at T0 and 40 plans at T2. Adherence to rehabilitation principles was measured by the method developed by Wunderink et al. [30]. This involved scoring the overall treatment plan (plan level) according to five criteria: whether goals were formulated; whether the treatment plan was written in the first person; whether there was space for clients' consent; whether evaluation dates had been planned; and whether emergency agreements were available. Furthermore, the treatment goals (goal level) of the following nine life domains were scored: housing; work and occupational activities; education; recreation; social contacts; meaning in life; self-care; mental health; and physical health. Each goal area is scored according the choose-get-keep model of psychiatric rehabilitation [31]: is the rehabilitation phase clear; is there a specified timeline; is there a clear task division; and is the client's role clear. Finally, the overall quality score of the plan was calculated by adding up the items on plan level and the goal level.

Finally, the professionals in each team were asked to fill out a fidelity checklist including the objectives of each step of the intervention by using a four-point scale ranging from *not at all* to *completely* to measure the extent to which they followed each step and whether they met the accompanying objectives.

Analyses

All interviews and observations were audio-recorded and transcribed verbatim. Analyses were performed using the framework method [32], a form of thematic analysis consisting of five distinct phases: familiarization; identifying a thematic framework; coding and indexing; charting; mapping; and interpretation [33]. The method is particularly suited for comparing and contrasting qualitative data, and due to the distinct steps, analyses are transparent and reproducible [33].

Atlas.ti was used for the initial open coding of a sample of the interviews, which were coded by the first author and discussed afterward with the second and third authors to ensure that all agreed with the codes. Categories and over-arching themes were identified; they formed the analytical framework on which the rest of the interviews were coded by the first author. Themes and subthemes were summarized in the form of charts and a framework matrix for interpretation and comparison. These were discussed with all authors. The results are reported according to the COREQ checklist [34]. Data from the structured questionnaires for the clients and professionals in the intervention and control groups, the treatment plans, and the checklist were analyzed using descriptive statistics. All quantitative analyses were performed using SPSS Version 24.

Results

The adherence to rehabilitation principles is shown for the 125 clients in both the control and intervention condition at baseline and 20-month follow-up (Supplementary Table 1). In almost all treatment plans, one or more rehabilitation goals were formulated. The prevalent treatment goals were (from most to least mentioned) mental health; self-care; social contacts; work; meaning in life; physical health; housing; daytime activities; and learning. The overall quality of the treatment plans was 5.2 (on a scale from 1 to 10). Most of the plans revealed insufficient adherence to rehabilitation principles; in no case was there substantial or full adherence.

In the following sections, the major themes regarding the implementation process and its influencing factors identified in the interviews with professionals, managers, and trainers are discussed, together with additional information from the intervision meeting observations and the structured questionnaires. The themes were: (1) attitudes toward and reasons for discussing victimization; (2) the process of implementation; (3) factors affecting the use of the intervention; and (4) the perceived added value of the intervention. The results from the client interviews are also presented.

Attitudes toward and reasons for discussing victimization

Victimization was considered by all the participants to be an important issue for discussion. The professionals described three reasons for using the Victoria intervention. First, victimization is seen as something inherent in people with severe mental health problems, and therefore the topic should be embedded in one's daily routine. Several of them argued that all of their clients experienced victimization on a regular basis, with some stating that victimization will become a greater problem in the future because of the changing care system and growing intolerance toward people with mental illness. One professional said that:

> *Those people all have a history. A lot of have experiences and you're not here for no reason. And um... so the chances are, if you're at FACT and you have victimization experiences, those chances are pretty high (P15).*

A second reason was that the intervention focuses on an undiscussed or oft-avoided topic. Victimization is not an easy subject to discuss and is sometimes avoided by both clients and professionals. One professional suggested that because victimization is inherent to the FACT population, many relate it to their psychopathology. Another professional confirmed that the topic often remains undiscussed: "In three-quarters of an hour you have to look at so many things ... I notice a very conscious reflection on these things, that I think this happens far too little" (P12).

Yet another reason was that, according to the professionals, victimization has an enormous impact on participation. They recognized that clients sometimes refrained from undertaking activities because they want to avoid disappointment. Many clients "have become so familiar with disappointments that it is more or less an expectation that things would turn out that way" (P4). Several argued that supporting social recovery is what the job of a case manager is all about, so victimization should be given more priority.

However, a few professionals had some doubts about the intervention. One argued that due to high workloads and a lack of staff, the priority should be on treatment and not on barriers to rehabilitation in cases of addiction and personality disorders. Another expressed her concerns about focusing on victimization thus:

> *But with the emphasis you put on victimization um ... you might also increase the likelihood that it's precisely about that. You know what I mean, right? So people sometimes don't move because they are victimized and so we have to pay attention to that. And then it's a benefit. Um ... but because you emphasize it so much, it can also be that ... and that's a bit ... you know, social workers ... social workers love trauma and victimization, huh? (P6).*

Comparison with care as usual

All experts-by-experience indicated that the steps of the Victoria intervention were nothing new. They already focused on victimization in their conversations with clients, asking about previous (negative) experiences and what preceded them.

> *But I have a, an easier entrance, I think, because I get to talk about my own experiences as well … I've been through um a lot of traumas. And also psychoses from traumas. So yes, then…it's already a bit natural that I'm really curious about how they…what they've been through, how their eh life situation is, eh…what they need, what they eh, eh…yes, I investigate that with the clients completely (P1).*

Most of the case managers admitted they addressed victimization with their clients, but not on a regular basis or as extensively as the Victoria intervention. A commonly expressed view was "I did have these kinds of conversations, but never so precise." One admitted the following:

> *I must say that I uhh, that I do find it a…. in that sense a useful or a beautiful intervention, because it (victimization) uhh maybe by some people often underexposed, while I myself always uhh without knowing the intervention already had the idea that I focused on people's recovery and why they do not come to recovery so to speak (P14).*

Finally, the case managers all acknowledged that they often wanted change too fast too soon, or that they often started offering solutions.

Process of implementation

Extent of application

Results from the structured questionnaires (Supplementary Table 2) show that, according to the professionals, 55% and 60% of clients were exposed to the intervention at T1 and T2, respectively. The professionals stated that most of their clients had the occasional Victoria conversation (52% at T1 and 48% at T2). A small percentage had a Victoria conversation often (15% at T1 and 11% at T2). The extent to which professionals discussed Victoria conversations with colleagues increased over time, from 29% at T1 to 43% at T2.

The professionals reported in the fidelity checklist that they generally went through all the steps of the intervention, with a sum fidelity score of 3.06 (with scores ranging from 0 to 4; Table 4). The two lowest-scoring items were responses to "To what extent are you not going along with the avoidance?" and "To what extent can you say for yourself that you have not been too quick to think in terms of solutions?" This suggested that they had the most difficulty applying these components of the intervention.

Table 4. Checklist of the steps of the intervention

To what extent … *M* (*SD*)[a]	**Mean score**
… do you know how this client is doing in terms of living, social contacts, and activities?	3.16 (0.96)
… do you have any insight into whether there is any avoidance of or stagnation in (social) activities?	3.21 (0.71)
… do you have insight into whether or not victimization experiences or other kinds of setbacks are linked to participation?	3.21 (0.71)
… are you not going along with the avoidance?	2.11 (0.57)
… do you have a clear picture of the experience?	3.11 (0.81)
… can you understand the intensity of the client's feelings?	3.21 (0.79)
… do you understand the causes (in terms of client behavior, the behavior of others, and the circumstances)?	2.95 (0.78)
… did you give the client sufficient recognition and understanding of the (causes of) their experience?	3.16 (0.96)
… do you understand discouragement and/or avoidance?	3.37 (0.83)
… do you have an idea of the client's desires that lay beneath their experience?	3.32 (0.48)
… do you have an idea of what the client was hoping to achieve?	3.16 (0.96)
… have you discussed whether another conversation about this experience is desirable?	3.37 (0.90)
… have you discussed whether and how to proceed with the original goal?	3.06 (0.87)
… do you have a view on how to proceed?	3.05 (1.03)
… can you say for yourself that you have not been very quick to think of solutions?	2.53 (1.07)
Overall score[b]	3.06 (0.42)
Was it possible to conduct a Victoria conversation with this client? (Yes) *n* (%)	16 (84.2%)

Note. [a] scores ranging from 0 (*not at all*) to 4 (*completely*). [b] Minimum = 2.20, maximum = 3.53

By contrast, in the qualitative interviews, the professionals indicated that they did not use the intervention extensively in their daily practice. While they valued it and thought that more attention should be paid to barriers to participation, they were unable to use the intervention as much as they would have liked to. The same can be stated for the teams. Most of the professionals explained that in their teams, neither the intervention nor victimization were discussed on a regular basis. Only in one team did clients who had meetings about their treatment plans the following week discuss the question of social functioning. The case manager of that team added that in other team meetings they also asked questions such as "Why is it that this client has issues with participating, why does he not go outside, or why did he quit his education" (P10) more often. According to the professionals, the main reason for not using the intervention in daily practice was because it was new and they were creatures of habit; they were only reminded of it in intervision meetings, after which it faded into the background again. Both trainers and case managers stated that intervision meetings consisted mainly of discussing potential clients rather than evaluating previous Victoria conversations.

Steps of the intervention in daily practice

The chief indicator of the Victoria intervention according to the protocol is when a client has issues with societal participation. According to the professionals, 34.4% of the clients were avoiding participation, and 33.6% stopped participating. The professionals confirmed that this was due to victimization in two-thirds of those cases (64% at T1 and 56% at T2; see Supplementary Table 2).

In the qualitative interviews, most of the professionals claimed that they applied the intervention flexibly, for example by starting to address victimization rather than the clients' struggles with societal participation. Those who used the intervention more thoroughly noticed that it helped to address victimization in terms of participatory stagnation; it opened doors, and they also learned "new" things about their clients: "… while if you go more in the direction of, 'Yes, but it's terrible what happened to you,' that is easier for them to bear. Then it becomes an easier subject" (P16).

Most experts-by-experience indicated that they used the steps of the intervention as intended, and thought it was *doable* if you take your time. They also said they took a very flexible approach to the sequencing of the steps, as the outcomes of each were related to personal experiences and stories, so required a personalized approach.

They also pointed out that they often recognized certain feelings themselves (e.g., shame and discouragement), and this made it easier for them to relate to the feelings of the client; they therefore understood the importance of the second step in particular. In most case manager interviews, this step was not discussed, though two of them concluded that "What I've noticed in particular is that, when I'm working with Victoria … is that, when you ask about this [victimization], I've noticed that people are often open about it, if you really pay attention, if you really try to listen" (P10).

Most professionals argued that participation-related victimization was not a topic clients put on the agenda; indeed, they avoided it altogether. A potential issue was that the professionals might along with them. They recognized that they needed to be aware of this and take the initiative to make it a topic of conversation.

The professionals struggled with applying the intervention in daily practice partly because each step required a considerable amount of time. One of the trainers argued that most case managers had a tendency to focus on recognizing and acknowledging negative experiences and offering solutions, to the point where the conversation was no longer about social functioning.

The case managers argued that the tendency to offer solutions too soon was an issue. The necessary time had to be taken to complete the first two steps (i.e., exploration and analysis). One professional stated that "I had to sit on my hands quite often (P10)." This tendency was confirmed in the intervision meetings when cases were being discussed: "I wouldn't come up with solutions myself, but I would ask 'what have you tried?.' ... then you want to follow through on that as well" (W23).

Finally, beginning the intervention could also be a challenge. Many of the professionals started with a clear suspicion that the client had been victimized. Only a few case managers indicated that they introduced the intervention when a client was struggling with societal participation. They were also the ones who used the intervention quite often. Some experienced difficulties in choosing the right moment; a client had to be in the *right* recovery phase. This was confirmed in the intervision meetings.

Usability

In general, the intervention was perceived as clear, logical, and comprehensive. The professionals argued that the steps and the accompanying handouts were easy to use. However, the problem with using the intervention in daily practice lay in a certain reluctance stemming from a fear of inflicting more trauma. They felt that discussing victimization experiences could cause their clients distress, even though most of them agreed that in the long run, this would be beneficial. The case manager of a client who worked as a sex worker on the streets and was suffering from addiction said:

> *I assume that he has experienced a lot of traumas. But I... also one of those ladies once said to me: yes, I use because I experience so much on the streets. I use to cope. And so I can forget those bad experiences. When I ask someone in depth, Where was it? And how was it? I find that uhm, yes, this does not quite fit my role then.. What if I'm rooting around in something that has bothered people for years? You have to know what you're doing (P11).*

Nevertheless, all the professionals said that they referred to a psychologist in their team if they suspected underlying trauma. They were also aware that this, in addition to using the trauma screener, is advised in the fourth step of the intervention. They argued that the intervention is not suitable for everyone. They agreed that for clients with psychosis or heavy addictions, the intervention should wait. Some were more hesitant than others: "If someone drinks 12-13 cans of beer a day, I don't have to have this conversation. ... Then I agree [with the client], if I come by uh, it is in the morning and [we agree] no alcohol" (P9).

Several preconditions for the application of the intervention emerged from the interviews. The most important one was that a narrative attitude requires time. Sitting down with the client and not being led by the delusion of the day creates a space for the client to be open. The downside of this is that professionals have to slow down and take more time with a client than is scheduled. Another precondition is having a connection or a good relationship with the client. This also creates a safe space in which they feel safe to open up about their victimization experiences, though having these kinds of conversations with new clients was not considered advisable.

Training

Attendance at the first training session was 97%, followed by 66% and 58% for the second and third sessions, respectively. In general, professionals perceived the training as 'well put together.' On the role play and fictitious cases, they were divided. Some thought this was insightful and others found it difficult to practice the intervention in a created situation. Finally, they preferred to have the second and third part of the training per team, instead of per organization.

The intervision meetings were not a priority in most of the teams, which led to a lower attendance rate or even rescheduling meetings. Case managers were too busy and, for example, clients' crises were of higher priority. This led to lesser continuity across meetings, because cases brought in at one meeting could not be followed up in the next. The input of cases was appreciated though and was perceived as practical and enlightening. However, it remained mostly talking about rather than evaluating actual conversations.

Factors affecting the use of the intervention

Three main factors were identified. Case managers have large caseloads that increasingly involve complex clients. This, coupled with the limited amount of time available, makes it difficult to sit down with a client and to take the time that is needed for the intervention. One of the professionals explained:

> *Often it's really a matter of investing, of time... And that, from day-to-day you just lack time. That is what's lacking. That you want to take the time, but that you still have to go like 'oh, in half an hour I have to go to the next appointment.' So there is always pressure there, like, I have to... And my clients notice that too (P10).*

The professionals argued that it was difficult to implement a new intervention and learn new skills because they had busy schedules, especially when other matters were more pressing (e.g., client crises). This issue was compounded by the high turnover in the participating teams during the 20-months of the study. This resulted in a greater focus on primary tasks and making sure clients were taken care of. The teams' knowledge and understanding of the intervention were correspondingly impacted, and new case managers had to be trained up.

Second, case managers and experts-by-experience felt that the importance of the intervention was not sufficiently recognized. Neither time nor space was available in their daily schedule, and there was a great deal of misalignment and poor communication. What would have helped, according to the professionals, was: (1) making the intervention part of formal processes, for example in electronic patient systems or in yearly team performance evaluations, and having it regulated and approved by management; and (2) creating the necessary room in people's schedules where they could apply it:

> *It must also be supported by management and seen as important. So I think it's from the bottom up, but also um... from the organization that's behind it. You can't expect people to have to do all sorts of things and then also have to implement ... something themselves (P15).*

The professionals indicated that, as case managers tend to work individually, it would have helped to integrate the intervention into the team setting, for example, in regular crisis meetings. Implementation would have also benefited from having a designated individual in each team who secured its place on the agenda. Additionally, some suggested that yearly booster training sessions would be helpful.

Perceived added value of the intervention

According to the professionals, the main added value of the intervention was that it forced them to sit back, listen, and take their time. This helped to create insight (for both themselves and their clients) and openings to discuss victimization experiences. As clients will usually only talk about negative experiences when the professional explicitly discusses them, the intervention made discussing what is a heavy and difficult topic more straightforward.

> *Because it's always about vulnerable things. Things that people would rather not... That would rather not be there. And the more you have of those kinds of things the more you actually forget that they play a role. And sometimes it is also just eh for the client very enlightening to eh to get the insight. Why do I do what I do? What exactly is there then... Why do I always fall into the same trap or why do I never succeed or.... What is it exactly? As far as I am concerned, this is a very nice instrument (P12).*

What was also achieved was that "you are connecting [with the client], you are giving someone the idea of 'hey, he/she is interested in what happened, why I am the way I am.'" (P13). The intervention provides a structured way of addressing the issue of caseloads and explicitly paying attention to clients who seem to be doing fine or are mentally stable but are not making much progress on societal participation. By using the intervention on a regular basis (and not only at intake), the professionals stated that they had gained insights into why their clients were struggling with societal participation or avoiding it altogether, what influenced certain choices regarding same, and learning about the clients' wishes regarding rehabilitation.

The responses of the clients to the intervention, according to the professionals, were generally positive. However, at first, some clients resisted discussing victimization experiences because they were distressing. Returning to them in a subsequent appointment seemed to help resolve this sticking point. Professionals who initiated the Victoria conversation by starting with negative experiences rather than with participation struggles noticed that clients were reluctant to take part. On the other hand, the professionals who started by trying to connect with the client, took their time, acknowledged feelings associated with negative experiences, and related them to struggles with participation, received positive feedback.

The professionals said that the intervention influenced their daily practice. The most important effect was that their overall awareness of both victimization and participation increased. Several professionals acknowledged that beforehand, they were less conscious of the impact of victimization experiences, but subsequently, they noticed avoidance or stagnation with participation more. Additionally, they mentioned that they could no longer simply assume that their clients were satisfied with their social functioning, but checking-in frequently and "connecting with the client, and not so much having a biased, but an inquisitive attitude. Well, that works" (P4).

Clients' conversations with professionals

Most of the clients discussed victimization or other setbacks related to societal participation felt that it was important to have such conversations (Table 5), though they did not think they had to discuss these topics more often.

Many of the clients mentioned in their interviews that they had issues with participation (such as a lack of familial contact, a small social network, and wanting voluntary work); only a few mentioned discrimination or victimization (such as arguments with neighbors and traumatic encounters with the police). Even though victimization was rarely a topic of conversation with their case manager, many clients discussed it with their family, social contacts, and in relation to their needs regarding societal participation. Additionally, many of their conversations were about daily matters, such as how the week had been going, or medication and symptoms.

In general, the clients do not recognize that a new intervention was being used. They claimed that conversations on victimization were rarely followed up. They received different types of advice from their case manager, but few were rehabilitation-related and were often practical. However, most of the clients were satisfied with their case manager; they felt a connection with them and that they were interested in what they liked doing. As was the case with the structured interviews, what they gained most out of their conversations was that they could vent their feelings, and they felt listened to and supported.

> *It is a kind of handholding … if things were going a bit less or so, I can always go to her. And we can then, you know, she can always assess how things are going, and yes, that is also the reason that when I e-mailed so to speak. Sometimes I e-mailed because I eh … because I then, yes I did not really feel good, and worried much eh … or something. And often it's better after I've written it off, so to speak, because then I've shared it and I know okay, you know, it's known and that always gave me peace (C16).*

Table 5. Clients on social activities and victimization or setbacks at 10- and 20-month follow-up (*N* = 326 at T1; *N* = 315 at T2)

	T1		**T2**	
	Intervention *M* (*SD*)	**Control *M* (*SD*)**	**Intervention *M* (*SD*)**	**Control *M* (*SD*)**
I have talked to my case manager in the FACT team about these kinds of experiences.	2.78 (0.99)	2.93 (0.92)	3.01 (0.70)	2.86 (0.89)
I don't talk enough about these kinds of experiences with my case manager.	1.64 (1.08)	1.50 (1.16)	1.65 (1.05)	1.63 (1.06)
I think it is important to talk about this experience with my case manager.	2.98 (0.87)	2.99 (0.81)	2.98 (0.77)	2.88 (0.87)
I find talking to my case manager about setbacks enlightening.	2.87 (0.92)	3.03 (0.71)	2.89 (0.77)	2.70 (0.90)
After discussing these experiences with my case manager, I feel relieved.	2.80 (0.88)	2.91 (0.79)	2.78 (0.77)	2.70 (0.79)
Talking to my case manager makes me feel that I have been heard.	2.96 (0.78)	2.93 (0.82)	2.91 (0.82)	2.84 (0.87)
Talking to my case manager makes me feel less uncomfortable.	2.67 (0.95)	2.82 (0.82)	2.68 (0.80)	2.59 (0.89)
Talking to my case manager will ensure that I am better able to deal with these kinds of situations in the future.	2.79 (0.83)	2.73 (0.87)	2.63 (0.81)	2.61 (0.90)
Talking about such experiences with my case manager helps in my recovery process.	2.86 (0.84)	2.85 (0.85)	2.80 (0.80)	2.71 (0.90)

Note. Minimum = 0, maximum = 4.

Discussion

The present process evaluation aimed to understand the trial effects by examining the implementation process (including training and use of the intervention), the factors that influenced this process, and the impact the intervention had on the clients. The results show that the professionals shared the urgency of paying attention to victimization and discrimination and its harmful effects on societal participation. They also found the intervention steps to be logical and the intervention protocol easy to use. Even though they said they discussed victimization more often with their clients, they did not always follow the steps. Furthermore, they remained reluctant to initiate conversations about victimization, mainly due to a fear that their clients might relapse, become traumatized, or feel insecure or uncomfortable about bringing it up and talking about it. However, when the professionals began a conversation on victimization, their subsequent experiences were positive. The clients did not relapse, which confirmed the findings of previous studies [20]. Additionally, they felt acknowledged. Using the intervention gave the professionals insights into their clients' rehabilitation wishes and allowed them the opportunity to discuss victimization experiences.

The different means we used to assess the extent of use of the Victoria intervention showed some discrepancies. The professionals indicated in the checklist that they mostly followed the intervention steps, and similarly, in the structured questionnaires, they reported that they used the intervention on over half of the clients. However, in the interviews and intervision meetings, even though they indicated they were more aware of victimization and addressed the topic more often, they took a flexible approach to the application of the intervention. Furthermore, they stated in the interviews that they were reluctant to use it and did so only cursorily.

The findings indicate that the professionals need more training in how to address victimization and should sit on their hands more often when engaged in conversations on this difficult topic. Extending the current intervention with more in-depth and real-life role-plays using actors and peer workers is advised, as well as annual refreshers.

What was notable was that the RCT showed the positive effects of the intervention on the discrimination that the clients experienced and on the acknowledgment of this [16]. It seemed that just addressing victimization helped societal participation. Higher fidelity to and the stricter use of the Victoria intervention might have enlarged the positive effects and improved other outcomes (including societal participation and victimization).

Several factors associated with victimization are often examined, including ethnicity. However, evidence is inconclusive; some studies found that ethnicity was a risk factor [35], and others established it as a (partially) protecting factor; when the majority in a (bad) neighborhood has the same ethnicity as the client, this appears to be protective [36]. On the contrary, Dutch studies do not show a difference between victims and non-victims in relation to ethnicity [37,38]. In our effect study [16], we also found that it had no predictive value on the outcome measures. As it may still have an influence on the dynamic of the conversations on victimization between mental health staff and their clients, and this was not addressed in the semi-structured interviews, future studies should address this topic more directly.

Mental health care still focuses on the treatment of symptoms rather than rehabilitation [39]. Concentrating on victimization experiences may lead to an overemphasis on the pain and emotions that clients experience. Several of the professionals used victimization experiences as the starting point of the intervention rather than participation issues, and this presented the possibility of the aforesaid. This accords with previous research [40]. Traumatic experiences should not be dwelt upon, but they should be treated. Such an approach is incorporated in the Victoria intervention in several respects. Those implementing it are required to start by discussing struggles with participation. In the third step, the mindset shifts away from the victimization experience toward the wish to participate. Finally in the fourth step, one of the options is trauma-focused treatment. Even though we paid attention to the need not to dwell on recent victimization experiences, future implementation of the intervention (and the accompanying training) should concentrate on this more.

In the training, intervision sessions, and interviews, we found that experts-by-experience understood the essence of the intervention and that it required time, but questioned whether they had the time for it. They pointed out that they were already using large parts of it. These findings were in keeping with previous studies. First, experts-by-experience adopted a strengths-based approach more than the other professionals [41], which can empower and instill hope in clients. By disclosing their own stories, it is possible for them to regain control over their illness [41,42]. Second, because the nature of the contact in the intervention is more low-key than is usual, so is the distance between the professional and the client. Third, experts-by-experience can discuss day-to-day life, such as how to overcome stigma, more often than would be the case with, say, psychologists [42]. This also encourages empathy, because experts-by-experience have similar experiences and can relate more to their clients [43]. In future implementations of the intervention, case managers will have to undergo a greater attitude shift than experts-by-experience.

We discovered that there were significant barriers to the use of the intervention on a regular basis, for example, increasingly heavy caseloads. This was a function of the way FACT teams tend to work. The professionals stated that 80% of their days should be spent on clients, but they have busy schedules and so have only a limited amount of time. The role of management in successful implementation is well-known [44]; we also found that a lack of support resulted in diminished use of the intervention. This needs to be addressed. The intervention should be made part of treatment plans and a component of team performance indicators.

Our intervention was interwoven into the Boston Psychiatric Rehabilitation method (BPR) [31]. All the teams involved in the intervention were certified FACT teams; however, the literature shows that scores on rehabilitation items are lower than other scores that comprise the overall FACT fidelity score [45]. Our findings confirmed this; while all the teams were trained in the BPR, adherence to rehabilitation principles was insufficient. We learned in the interviews that team meetings focused on crises and that the professionals worked mostly individually. A recent study of FACT teams [46] concluded that, although their fidelity scores were low, rehabilitation efforts increased over time. However, when rehabilitation principles had been more standard practice among the teams in the present study, the Victoria intervention would have offered even greater improvements.

In addition, the FACT teams' mission was ambiguous. This is an important issue because mission determines successful implementation. In the Netherlands, FACT teams provide care for relatively stable clients using rehabilitation methods and support them during psychiatric crises. Continuity of care provides stability for clients. However, due to recent policy changes [18], FACT teams have been forced to adopt a more treatment-oriented approach and focus less on care per se. Together with regional differences in client populations and organizational networks, FACT teams specialize in, for example, first psychosis episodes or addiction, or focus on treatment at the expense of rehabilitation. The Victoria intervention can help address this issue.

Strengths and limitations

The present study has yielded valuable information on the significance of recognizing and addressing victimization in clients and the difficulties professionals have discussing victimization with their clients. Other strengths of the study include its mixed-methods design and the large sample of participants and number of observations. The study has some limitations. First, we included clients who received the intervention according to their case managers, so we could not measure its true extent. Secondly, while we measured the extent of use by employing several methods, we did not design a bespoke fidelity scale that might have proven more accurate.

Conclusion

Results from this process evaluation indicate that the intervention increased awareness of victimization. Even though the steps of the intervention were not always followed as they should have, the professionals involved reported positive experiences. The intervention gave them greater insights into their clients' rehabilitation wishes and allowed them to discuss victimization experiences. This process evaluation has an important added value in that it gave us a better understanding of the effect evaluation of the intervention. Our findings might facilitate the development and implementation of other interventions in community mental health care settings. In particular, it is hoped that the Victoria intervention might aid clients' societal participation.

Appendix

Table S1. Rehabilitation principles in treatment plans (*N* = 125)

Plan level	N	%
Rehabilitation goal formulated	122	97.6
Signing space for service user consent	104	83.2
Date planned for treatment plan evaluation	84	67.2
Plan formulated in the first person	75	60
Emergency agreements	51	40.8
Goal area present in treatment plan		
Daytime activities	24	19.2
Social contacts	58	46.4
Housing	56	22.8
Work	56	44.8
Learning	5	4
Meaning in life	48	38.4
Self-care	62	49
Mental health	113	90.4
Physical health	39	31.2
Degree of adherence to rehabilitation principles - Quality score		
1 (0-3) No adherence	22	17.6
2 (4-6) Insufficient adherence	90	72
3 (7-8) Sufficient adherence	13	10.4
4 (9-10) Substantial/full adherence	0	0

Table S2. Case managers and experts-by-experience on victimization and Victoria conversations on 10- and 20-month follow-up *(N = 305 on T1; N = 288 on T2)*

	T1		T2	
	Intervention n (%)	**Control n (%)**	**Intervention n (%)**	**Control n (%)**
Does this client avoid social participation?				
No, not at all	30 (19%)	47 (32%)	42 (27.8%)	48 (35%)
Not really	59 (37.3%)	41 (27.9%)	40 (26.5%)	39 (28.5%)
Yes, somewhat	49 (31%)	37 (25.2%)	52 (34.4%)	34 (24.8%)

Table S2. *Continued*

		T1		T2	
		Intervention n (%)	**Control n (%)**	**Intervention n (%)**	**Control n (%)**
Yes, definitely		20 (12.7%)	18 (12.2%)	17 (11.3%)	16 (11.7%)
Not applicable		0 (0%)	4 (2.7%)	0 (0%)	0 (0%)
Has this client stagnated in or stopped social activities?					
No, not at all		22 (13.9%)	40 (27.2%)	32 (21.5%)	36 (26.3%)
Not really		64 (40.5%)	45 (30.6%)	47 (31.5%)	50 (36.5%)
Yes, somewhat		55 (34.8%)	33 (22.4%)	50 (33.6%)	33 (24.1%)
Yes, definitely		13 (8.2%)	23 (15.6%)	18 (12.1%)	18 (13.1%)
Not applicable		4 (2.5%)	6 (4.1%)	2 (1.3%)	0 (0%)
Is this due to victimization?					
Yes		61 (63.5%)	31 (37.8%)	51 (56%)	29 (37.7%)
No		31 (32.3%)	45 (54.9%)	37 (40.7%)	41 (53.2%)
Don't know		4 (4.2%)	6 (7.3%)	3 (3.3%)	7 (9.1%)
In the past 9 months, have you ever had conversations about this victimization or other setbacks?					
Yes		130 (82.8%)	126 (85.7%)	120 (79.5%)	99 (73.3%)
If yes, how often?	(Almost) never	15 (11.5%)	8 (6.3%)	12 (10%)	15 (15.2%)
	Rarely	18 (13.8%)	18 (14.3%)	14 (11.7%)	12 (12.1%)
	Occasionally	66 (50.8%)	74 (58.7%)	75 (62.5%)	58 (58.6%)
	Often	31 (23.8%)	26 (20.6%)	19 (15.8%)	14 (14.1%)
Have you held a 'Victoria' conversation with this client in the past 9 months?					
Yes		83 (55%)	-	87 (60%)	-
If yes, how often?	(Almost) never	15 (18.3%)	-	17 (21.3%)	-
	Rarely	12 (14.6%)	-	16 (20%)	-
	Occasionally	43 (52.4%)	-	38 (47.5%)	-
	Often	12 (14.6%)	-	9 (11.3%)	-
Did you also discuss the content of the Victoria conversation with your colleagues?					
Yes		40 (29.4%)	-	57 (43.2%)	-

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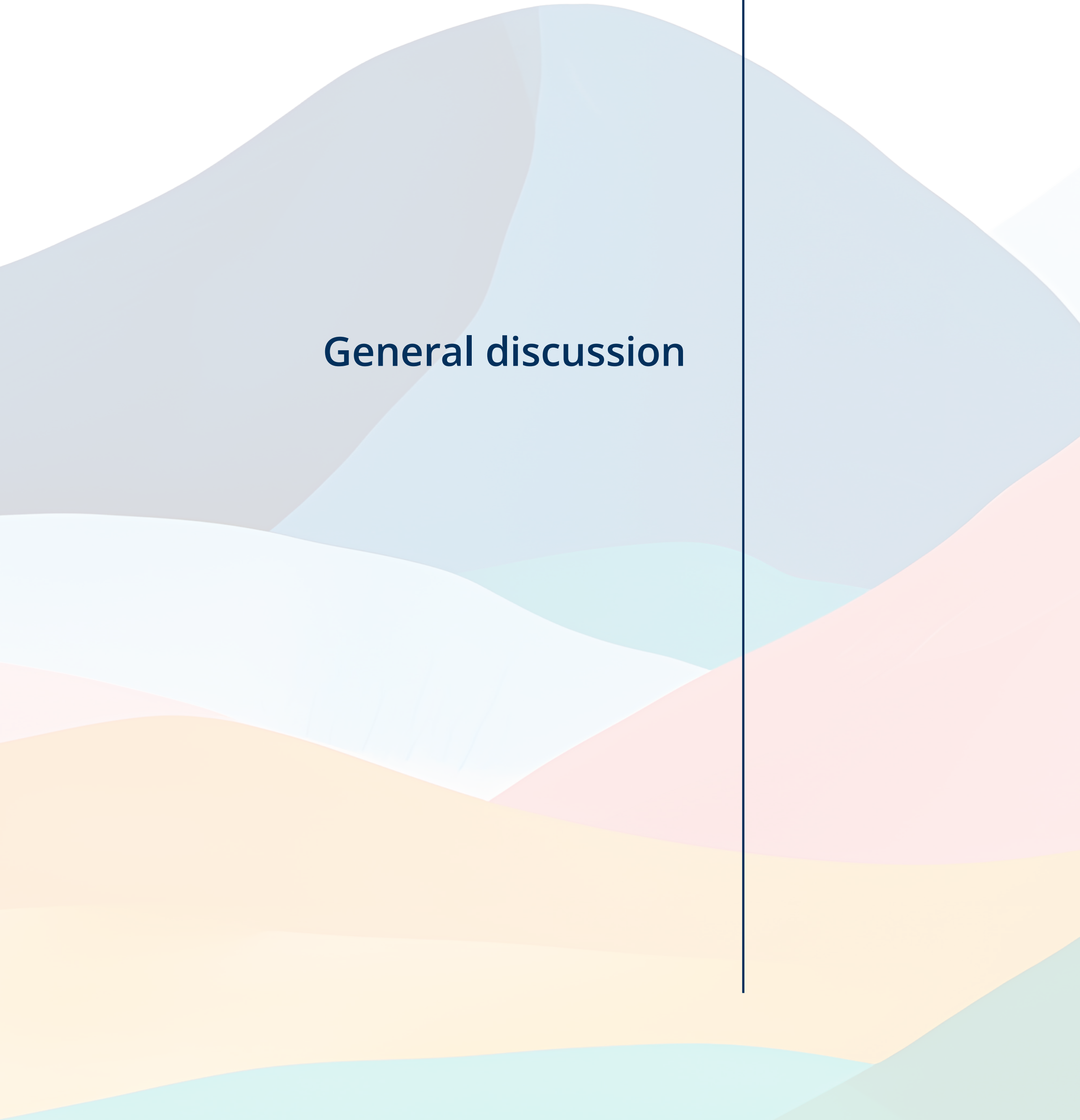
7

General discussion



Individuals with severe mental illness (SMI) are increasingly transitioning from institutional settings to live within society. Despite a stronger focus on rehabilitation and societal recovery in recent years [1,2], their level of societal participation remains significantly lower compared to the rest of the population [3-5]. While engaging in society, individuals with SMI encounter various, often under-recognized risks. These include criminal victimization, stigma and discrimination based on their psychiatric diagnosis. These challenges can lead to discouragement and social withdrawal [6-11].

However, risks are an inherent part of life and can serve as valuable learning opportunities on an individual's road to recovery. This aligns with the concept of "dignity of risk", which promotes risk management while encouraging participation, asserting that clients have the right to take reasonable risks [12,13]. Mental health professionals, however, face a continuous balancing act between facilitating risk-taking and ensuring safety in rehabilitation and recovery-oriented mental health care [14,15]. This highlights the need for further professional guidelines in this regard.

Therefore, this dissertation explored the role of victimization, including stigmatization and discrimination, in the participation of individuals with SMI. It investigated the variation in victimization rates, perpetration rates, experiences of discrimination, and social functioning rates among this population. This aimed to enhance our understanding of the factors contributing to reducing these barriers to participation. Additionally, this dissertation described the development and evaluation of a victimization-informed intervention within community mental health care. This included the intervention's implementation process and its effectiveness in reducing victimization, enhancing recognition and coping mechanisms, and ultimately fostering societal participation.

This chapter highlights the main findings of this study, followed by an in-depth interpretation of those findings. Subsequently, we discuss the methodological considerations of this dissertation, the implications of the research findings for community mental health care and future research, and end with an overall conclusion.

Summary of main findings

This section outlines the key findings from each chapter.

1. ***Individuals with SMI exhibit three subgroups concerning their experiences with victimization, perpetration, discrimination, and societal participation.***
2. ***These three subgroups, furthermore, demonstrate varying care needs, offering insights for mental health professionals to provide customized support for their safe participation.***

In Chapter 2, these results were derived from latent class analysis (LCA) conducted among 395 individuals with SMI receiving treatment in FACT teams. Compared to the rest of the population, all three classes scored higher on victimization and lower on societal participation [16,17]. The "General Difficulties class" (28.8% of respondents) experienced the fewest victimization incidents, but still reported 7% more incidents than the rest of the population. This class also experienced the least discrimination and had the highest societal participation scores. The "Discriminated and Avoiding class" (36.4%) exhibited moderate levels of discrimination, victimization, and perpetration. However, they had the lowest scores in societal participation and social support and felt least equipped to handle discrimination. The "Victimized and Perpetrating class" (34.4%) had the highest rates of discrimination, victimization, and perpetration. Surprisingly, they showed intermediate societal participation scores, but the most difficulties in psychosocial functioning, self-efficacy, and quality of life, making them particularly vulnerable. These findings highlight the pervasiveness of victimization among individuals with SMI (46% reported victimization and 17.5% reported perpetration in the past year. The existence of distinct classes based on these experiences emphasize the need for tailored support or recovery approaches for each group. Furthermore, it underscores the importance of addressing the impact of victimization on societal recovery within community mental health care.

3. ***Throughout the development process, we engaged various professionals, including mental health nurses, experts-by-experience, and managers.***
4. ***The Victoria intervention offers guidance for mental health professionals to assess demoralization, particularly due to victimization, and guide clients towards safer participation in society.***

The intervention aimed to assist professionals in recognizing victimization experiences as potential barriers to societal participation in their daily practice. During the iterative development process of the Victoria intervention, detailed in Chapter 3, several elements emerged to address the inherent contradictions in promoting safe participation. Firstly, the literature search identified several concepts and intervention components. The concept of dignity of risk suggests that mental health professionals may inadvertently discourage clients from taking necessary risks for growth and development by overprotecting them, thereby affecting their self-esteem, hope, and future perspectives negatively. Empowerment, understanding the reasons behind demoralization, and fostering a sense of connectedness through acknowledging struggles were found to be supportive of recovery [18,19]. Intervention strategies include shared decision-making, community integration, and positive risk management, all aligned with the dignity of risk principle [12,20]. Secondly, focus groups identified barriers to social participation at three levels: the client, the client's network, and the mental health professional, including for instance, lack of self-esteem, fear of relapse, lack of belief in resilience, lack of a safe home environment, not connecting to the client's narrative. Solutions to these barriers, such as integration of the intervention into existing rehabilitation methods, focusing on the individual's strengths, and connecting to his/her narrative, were incorporated into the intervention. Thirdly, the pilot revealed that professionals preferred focusing on solutions rather than discussing barriers to participation. Additionally, concerns arose regarding initiating the intervention with clients experiencing severe psychotic symptoms and substance abuse. Consequently, expert meetings led to targeting the entire FACT population and incorporating concrete follow-up steps, including a trauma screener, into the intervention to address these issues. These refinements culminated in the final Victoria intervention, presented in Figure 7.1.

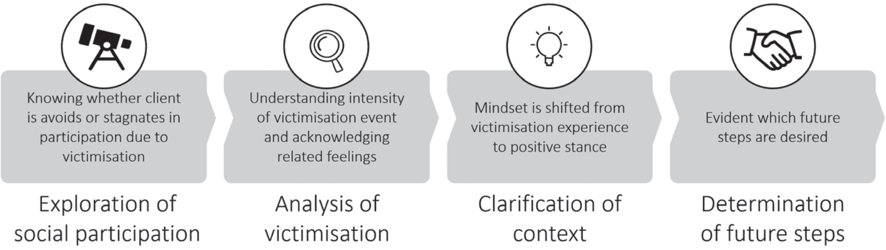


Figure 1. The four steps and goals of the Victoria intervention

5. ***Utilizing the Victoria intervention does not lead to increased future victimization or decreased psychosocial functioning, indicating that discussing victimization experiences is safe.***
6. ***Implementing the Victoria intervention, i.e., addressing victimization experiences related to demoralization, positively impacts the acknowledgment of victimization experiences and recovery support, and experienced discrimination among individuals with SMI.***

In the cluster RCT (see Chapter 4 for the design), a group of individuals was exposed to the Victoria intervention (*n* = 216) and compared to a group receiving care as usual (*n* = 184) (see Chapter 5). Before baseline measurement, FACT fidelity audit results were examined to ensure comparability and quality check, revealing relatively low scores on rehabilitation items. To ensure comparability in quality of their rehabilitation skills, all participating teams underwent additional training in the Boston University approach to Psychiatric Rehabilitation (BPR) just before baseline measurement. The study found no significant differences between the intervention and control group in societal participation and victimization rates. Unexpectedly, both groups reported increases in experienced and anticipated discrimination. However, the Victoria intervention had a small, yet significant protective effect, mitigating the increase found in experienced discrimination. More importantly, the Victoria intervention led to positive changes for participants. Individuals who received the intervention reported feeling more acknowledged and supported in their recovery journey. No intervention effects were observed for secondary outcomes such as self-efficacy, quality of life, and psychosocial functioning. Importantly, discussing victimization experiences within the intervention did not trigger relapses in therapy. Neither group experienced increases in criminal victimization or perceived unsafety, nor decreases in quality of life or psychosocial functioning. This finding highlights the safety of addressing victimization experiences during rehabilitation.

7. ***The Victoria intervention led to a significant increase in professionals' awareness and acknowledgment of victimization among their clients.***
8. ***However, implementing this intervention in practice proved challenging. Professionals did not consistently utilize the intervention and applied the steps with varying degrees of flexibility.***

Finally, a process evaluation examined the implementation of the intervention for this study to identify areas for improvement (Chapter 6). This evaluation focused on training experiences, usage patterns, factors influencing the implementation process, and perceived intervention impact on individuals. Most individuals expressed satisfaction with the support they received and felt a positive connection with their case manager, feeling listened to and supported. However, conversations about victimization with case managers were rare, with discussions primarily centered around practical and daily matters. Trained professionals generally viewed the Victoria training sessions positively, finding the intervention steps logical and the protocol easy to use. Nevertheless, professionals encountered difficulties initiating conversations about victimization and, when initiated, did not always adhere to the intervention steps as intended. Overall, professionals remained reluctant to talk about victimization as they felt it was a hard topic to address. High caseloads, complex clients, and staff turnover were cited as hindrances. These implementation challenges, such as limited discussions about victimization and professional reluctance, might partially explain the minor impact on the outcomes observed in the RCT.

Discussion of main findings

The findings of this dissertation have led to four themes for discussion, which will be elaborated on below. First, a better understanding of the consequences of victimization for societal participation; second, reflections on the implementation of the Victoria intervention in practice; third, the effect of the intervention on social participation; and fourth, the effect of the intervention on victimization, stigmatization, and discrimination.

A better understanding of the consequences of victimization for societal participation

This dissertation aimed to shed light on how victimization, including stigmatization and experienced discrimination, act as a barrier to social participation. Chapter

5 demonstrated that societal participation rates remained stable across the three measurements in both the intervention and control group. This aligns with previous studies indicating relatively stable and low participation rates compared to the rest of the population [21-23]. Similarly, employment rates mirrored those reported elsewhere [24-26].

Notably, victimization did not act as a barrier for every individual, or in a similar manner. Through LCA, we identified a subgroup termed the "Victimized and Perpetrating class", which exhibited relatively high scores in social functioning despite experiencing the highest rates of victimization and perpetration. This finding is consistent with recent research in individuals with schizophrenia, suggesting that those with overlapping experiences of violence and victimization may actually demonstrate higher social functioning compared to individuals solely experiencing victimization [27]. However, the "Victimized and Perpetrating class" also reported the most challenges in other areas such as psychosocial functioning (HoNOS) and self-efficacy (MHCS), highlighting the multifaceted nature of societal participation. Moreover, victimization does not always negatively impact societal participation, and better social functioning does not always imply better overall functioning. In the future development of the Victoria intervention, it is crucial to integrate this understanding into the initial step, where stagnation or avoidance of participation is explored. It should be clear to the professional in which specific domain of participation this avoidance is occurring.

Other studies have primarily linked property victimization to a risky lifestyle and poor social functioning, including substance use and perpetration of crimes (the victim-offender overlap) [28,29]. While our study did observe a victim-offender overlap, it was not limited to property crimes. Digital and total victimization were associated with total perpetration, and personal victimization and experienced discrimination were associated with personal perpetration (Chapter 2). The "Victimized and Perpetrating class" in our LCA exhibited the highest rates of all types of victimization and reported the most issues with substance use according to professionals. This suggests that risky lifestyles may contribute to various forms of victimization, at least for a subgroup of individuals with SMI, as was the case in our study.

Various explanations for these findings are plausible. One explanation is simply the exposure to social contacts; the more people interact with, the higher the chance of experiencing victimization. Another explanation lies in the model developed by Hiday, one of the first to propose a model explaining the interplay between mental illness, victimization, and perpetration [30]. The model suggests that victimization and perpetration are linked through many paths. Both the direct social network and the larger social environment play an integral part in both causing and preventing victimization and violence [30]. For example, violence can occur in tense social situations, but these situations may arise due to an environment where violence is accepted. Another explanation is that conflictual social relationships, such as those involving exposure to more stressful situations, less emotional regulation, and struggling with socially appropriate deference, potentially exacerbate vulnerability to victimization [27,31]. Additionally, similar to having a helpful social support system [32], living in a cohesive and safe neighborhood can serve as a protective factor as well and increase a sense of community [33-36]. Therefore, inclusion of individuals with SMI should not be seen outside the context of the neighborhood they live in or the community they participate in [37-39]. For these reasons, it is important to not reduce societal participation to one single score, but to remain aware of its several subdomains, such as employment, interpersonal relationships, social and recreational engagement, housing, neighborhood social cohesion, and daily living. Mental health professionals should be aware of clients' neighborhood social capital and collaborate closely with social workers who possess insights into neighborhood dynamics. Finally, it is important that encouraging social engagement may carry an unintended risk of victimization, and professionals as well as clients should be aware of these risks and work together to manage them, rather than avoiding social interaction altogether [15,40]. In a rehabilitation trajectory, therefore, more adequate support is needed to manage the (necessary) risks that occur during recovery, following the concept of dignity of risk, while respecting the client's personal vulnerabilities and strengths.

Reflections on the implementation of the Victoria intervention in practice

Despite all the efforts of the mental health organizations, management teams, researchers, intervention developers, and trainers, implementing the Victoria intervention in daily practice proved challenging. While professionals recognized the importance of addressing victimization and expressing willingness to do so, they reported limited use of the intervention (Chapter 6). They often applied its steps with flexibility, and only half of the clients received the intervention according to their professionals, and among those, most individuals only underwent occasional Victoria conversations. These findings underscore the complexity of integrating well-developed and supported interventions into daily practice [41]. Consequently, this highlights the need for reflection on implementation and adherence, since the way the professionals have used the intervention obviously impacted the results, and are food for thought for future victimization-informed interventions.

First, professionals exhibited reluctance in initiating conversations on victimization. Despite evidence demonstrating the safety of addressing victimization and comprehensive training provided [42], professionals cited fear of relapse and triggering past trauma as significant barriers. This reluctance persisted even after training, aligning with research indicating that many professionals do not routinely address victimization [14,43,44]. Efforts to educate and support mental health staff in systematically addressing victimization should be intensified in light of these challenges.

Second, professionals encountered difficulties in navigating the nature of clients' victimization experiences. Initiating conversations with clients about victimization instead of focusing on participation issues as intended led to challenges in further applying the intervention and met resistance from clients. This suggests that a focus on generalized recent victimization rather than specific incidents may overly emphasize the pain and emotions that individuals experience (Chapter 6). When demoralization in participation is diffuse and not linked to one specific victimization experience, this complicates further application of the intervention. Further development of the intervention should provide more clearer guidance on how to address specific participation domains and victimization incidents, or on demoralization in participation more effectively.

Third, while the intended sequence of the intervention was not always followed, professionals did demonstrate improved skills in recognizing and addressing the impact of victimization. They effectively applied the initial steps, emphasizing connectedness and acknowledging individuals' pain and struggles, reflecting a positive effect observed in the RCT. The process evaluation also revealed an increase in professionals' awareness of victimization.

Fourth, providing professionals with clearer guidance on follow-up steps could further enhance intervention implementation. Professionals participating in the pilot highlighted the need for clear closure and follow-up options after initial Victoria conversations. The intervention was subsequently modified to include follow-up options such as restarting the BPR action plan, utilizing a Trauma Screening Questionnaire for potential referral to trauma-focused treatment, conducting a second Victoria conversation if needed, and involving family or friends in ongoing victimization situations. These follow-up options show that the Victoria intervention was intended to focus on awareness and acknowledgement and consequently act as a precursor to identifying additional trajectories or interventions. Our LCA study highlighted the diverse experiences of individuals with SMI regarding victimization and societal participation. Each subgroup within this population could benefit from tailored follow-up options, extending beyond those outlined in Chapter 3. For instance, the "Discriminated and Avoiding class", characterized by low satisfaction with friendships and minimal social support, might benefit from a resource group [45]. The "Victimized and Perpetrating class" frequently engaged in conflict-prone relationships, might find the Self-wise, Other-wise, Streetwise (SOS) training beneficial. This training program focuses on increasing resilience, reducing vulnerability to victimization, and improving emotion regulation and conflict resolution skills [46]. Despite the inclusion of various follow-up options in our intervention, professionals expressed reluctance in addressing victimization experiences (Chapter 6). This reluctance could stem from professionals' limited awareness of these options beyond trauma-focused treatment, or uncertainty regarding the appropriate timing and selection of follow-up interventions. Given these challenges, particularly with the third and fourth steps of the intervention, future research should explore strategies to support professionals in effectively utilizing these options, potentially through participatory action research.

Challenges in implementing rehabilitation methods in community mental health care
The adoption of rehabilitation methods, specifically the utilization of the BPR, in community mental health care practice could contribute to the relatively low adherence to the intervention. On one hand, there has been an increasing emphasis on dimensions beyond clinical recovery, encompassing personal and societal recovery in recent years [47]. Mental health care organizations increasingly offer interventions like peer support groups and supported employment [48]. Additionally, there is a growing emphasis on rehabilitation and recovery in education, ensuring that professionals are adequately trained in rehabilitation methods upon entering mental health care practice. On the other hand, despite this focus on training, establishing consistent rehabilitative support remains challenging. This is evidenced by the low scores on the rehabilitation items in the FACT audit compared to other domains, along with the consistently low and stable societal participation rates [47,49]. Client interviews in Chapter 6 further support this notion, revealing infrequent discussions on rehabilitation topics, with conversations primarily revolving around daily concerns like weekly updates, medication, and symptoms. These findings align with previous studies that identified insufficient focus on recovery and participation in FACT teams [50], and challenges with model fidelity in the BPR [51]. Given that our intervention assumes a baseline proficiency in rehabilitation methods within the teams, the absence thereof may account for the lower implementation rates and the lack of outcomes in the RCT. This underscores the need to prioritize strengthening the implementation of existing rehabilitation methods within community mental health care.

Addressing victimization experiences: effects on societal participation

Our initial hypothesis was that by addressing the impact of discrimination and victimization on societal participation, the latter would improve. Unfortunately, the intervention did not yield a statistically significant effect on participation (Chapter 5). This finding suggests that societal participation may be more complex than anticipated, and that even well-trained teams might struggle to achieve this goal, especially when tackling issues like discrimination and victimization.

Despite a growing emphasis on rehabilitation in recent years, integrating this focus into daily mental health care practice remains challenging. The limited attention given to rehabilitation or participation within the teams could partly explain the lack of effectiveness observed in interventions targeting these areas.

Furthermore, there may be additional explanations for the lack of effect observed with the Victoria intervention itself. As indicated by the process evaluation, one of these explanations might include the intervention's indirect approach to victimization and societal participation. In essence, the intervention was designed to lay the groundwork for follow-up steps. Our intention with the Victoria intervention was for the victimization experience to be recognized and acknowledged, and explore how it hinders participation before progressing to solutions (Chapter 3). However, we encountered several challenges. First, we found that victimization does not act as a barrier for every individual in the same manner. The intervention seems most effective when it starts by addressing participation issues, followed by an exploration of how victimization impacts these issues, rather than focusing solely on the victimization experience itself. Several professionals struggled with this initial step. By starting off at a victimization experience, you may not end up at participation problems. Second, many professionals struggled with the third step of the intervention, which involves understanding the underlying rehabilitation wish or goal (Chapter 6). While individuals felt acknowledged in their victimization experience and supported in their recovery journey during the first two steps (Chapter 5), their mental health professionals did not consistently follow through with the remaining steps as intended. As discussed earlier, providing more guidance on how to focus on specific participation domains, rather than on general demoralization, and clearly defining initial goals could improve implementation. However, full implementation of the intervention does not guarantee an immediate effect on societal participation. It requires time and targeted follow-up actions. Moreover, the first step, 'Exploration of societal participation', should be repeated regularly as part of standard rehabilitation, as clients' situations evolve over time, and so do their participation challenges. It is important to acknowledge the pressure crisis management places on rehabilitation efforts within mental health care. Future research could explore how a positive risk approach towards rehabilitation can be fostered within teams facing constant crisis situations.

Addressing victimization experiences: effects on victimization, stigmatization, and experienced discrimination

Our findings indicate that addressing the impact of victimization experiences, particularly in relation to societal participation issues, did not lead to a reduction in victimization itself within the study period given the implementation level. Subgroup analyses focusing on clients who engaged in Victoria conversations, as reported by their professionals, also yielded no significant effect on victimization rates. Several explanations, beyond the methodological challenges discussed in Chapter 5 (e.g., the skewed distribution of criminal victimization incidents), could account for these results.

Our study included individuals with a relatively low prevalence of recent victimization incidents compared to other studies [46,52]. An intervention effect might be more readily observed in a population with a higher baseline rate of victimization. Future research should target clients who have experienced one or more victimization incidents and monitor them over an extended period. An alternative explanation could be that the intervention may not have specifically addressed neighborhood factors that contribute to victimization risk. Previous studies suggest that a sense of inclusion in the neighborhood may serve as a protective factor against societal participation barriers [34,35], and addressing neighborhood social inclusion issues could potentially prevent future victimization. As this aspect was not explicitly addressed in the intervention, further development could involve incorporating an additional step focused on assessing and improving the client's social support system or integrating the Victoria intervention into the resource group method [53].

Anticipated stigmatization increased in both groups over time, and no intervention effect was found. Experienced discrimination also increased in both groups over time , albeit with a mitigating effect observed in the last measurement for the intervention group. Apart from the increased awareness factor mentioned previously as a contributor to this increase (Chapter 5), the difference in effects observed for stigma and discrimination aligns with findings from previous studies, indicating that anticipated stigmatization and experienced discrimination act as two separate concepts.

Nevertheless, a substantial body of literature has established a relationship between experienced discrimination and anticipated stigmatization. Ye et al. [54] argue that increased anticipated stigmatization leads to reduced experienced discrimination; as individuals may avoid situations out of fear of stigma or rejection, thereby minimizing opportunities for actual discrimination. Furthermore, recent research in the Netherlands indicates that the link between victimization and anticipated stigmatization is fully mediated by experienced discrimination [55], supporting the "why try" effect theory, which posits that frequent experiences of discrimination heighten the likelihood of social withdrawal due to anticipated stigmatization. However, several studies have found that discrimination is more closely associated with social factors, whereas anticipated stigma is linked to psychological factors. For instance, a global study by Lasalvia et al. [56] revealed that half of the participants reported anticipated discrimination in familial and employment contexts, even in the absence of experienced discrimination. Similarly, other studies have shown that the anticipation of mistreatment can lead to anticipated stigmatization without actual experiences of discrimination [57,58]. While experienced discrimination may contribute to the internalization process and subsequent anticipated stigmatization, it may not be the sole determinant [59]. The intervention's impact on experienced discrimination could be attributed to social factors associated with discrimination, as identified in previous studies, and not specifically with anticipated stigmatization [56,60]. Addressing problems with societal participation may enhance clients' social skills, thereby facilitating better coping with discrimination and fostering resilience [61], thus explaining the observed effect on discrimination. Further research is needed to unravel the complex interplay with societal participation.

Methodological considerations

In this section, we will discuss the main considerations regarding the design of the entire study and research process.

Inherent to the Victoria intervention is the expectation for mental health professionals to adopt a more recovery-oriented approach. This includes a positive risk approach that focuses on the process of recovery rather than solely on immediate solutions [62]. This requires a culture shift, which as addressed earlier, probably requires a longer period of time than what was feasible within the scope of this study. Additionally, this cultural change needs broader implementation and reinforcement within the practice itself. The present study may contribute to this understanding. Furthermore, while our randomized controlled trial (RCT) results demonstrated the initial success of the first steps of the intervention, particularly in terms of recognizing and acknowledging experiences, it did not result in a decrease in victimization experiences or an increase in societal participation. Despite having a final follow-up measurement at 20 months, which is comparable to or even longer than other studies aimed at preventing victimization [46,63,64], this might be too short to expect behavioral changes in professionals and corresponding effects on clients [65]. A longer follow-up period could also reveal if the increase in stigma and discrimination levels remains constant, declines, or stabilizes over time.

Examining the implementation of the Victoria intervention alongside the RCT provided valuable insight into contextual factors, their interaction with the intervention, as well as the responses of clients and the quality of intervention delivery [66,67]. However, this approach also revealed some challenges. Professionals received training on using the intervention during client conversations, meaning we measured an indirect effect on clients. Additionally, the built-in flexibility of the intervention allowed for customization and adaptation to everyday practice, but made it difficult to quantify the specifics of conversations between case managers and clients. The process evaluation interviews revealed that these intervention characteristics partly contributed to the lack of an intervention effect. Nonetheless, it is essential to view the contextual factors of the setting as integral components of the system in which the intervention was implemented, rather than solely as challenges to its use [67]. For instance, achieving standardization in the traditional sense was not feasible for the Victoria intervention, as tailoring the intervention to the client's needs was an essential part of its implementation.

Some critical reflections on the implementation strategy of the Victoria intervention are also warranted. Our study highlights the importance of a well-developed implementation strategy. While this dissertation included piloting the intervention, expert panel feedback on the final version, and a comprehensive training protocol, an implementation plan could have further enhanced the intervention delivery [68]. Such a focused and structured approach would have provided more insight into the target groups of the intervention and the necessary changes in knowledge, attitude, and behavior. In this study, contextual factors were examined after the implementation through the process evaluation. With an implementation plan, we could have also anticipated preliminary contextual factors at different levels. Successful change requires a more rigorous focus on the implementation process, including time investment and continuous evaluation, to determine if adjustments are necessary. In other words, implementation is an iterative, cyclical process that should incorporate client feedback on discussing victimization and professional feedback on applying the intervention in daily practice.

In hindsight, conducting a full-blown feasibility study would have benefited the implementation of the Victoria intervention and its subsequent usage. This type of study examines the feasibility and sustainability of implementing the intervention on a larger scale and addressed potential barriers beforehand [69]. On a much smaller scale and less rigorous, we examined potential barriers in the two pilot teams (Chapter 3). For example, professionals suggested integrating the intervention into regular team meetings to enhance sustainability. The process evaluation also revealed that professionals encountered challenges in incorporating the intervention into their daily practice, leading to a decline in focus and usage over time. Intervision meetings often served as reminders to utilize the intervention. A feasibility study could have provided concrete insights and tools to address the reasons why case managers were hesitant to discuss victimization with their clients.

Overall, the intervention would have benefited from further development before testing its effects in a full-blown trial. The process evaluation results indicated that addressing victimization in individuals with SMI was more challenging than initially anticipated with the Victoria intervention. This dissertation offers some guidance for further development, including providing more guidance on targeting specific participation domains, understanding the nature of victimization incidents, incorporating clients' reactions to victimization (Chapter 2), and addressing follow-up steps.

Implications for future development of victimization interventions for community mental health care

Mental health professionals need to be better equipped to support clients dealing with victimization experiences, including the impact on their lives

The ten-year I program 'Violence against Psychiatric Patients' provided valuable insights through six intervention studies. These studies explored the prevalence and risk factors of victimization in various groups of mental health care clients, as well as the effectiveness of interventions in preventing and addressing victimization. Despite the mixed results in reducing victimization incidents across these interventions, several lessons can be drawn from these studies. In general, even with targeted interventions, it remains difficult to detect, address, and prevent (re)victimization in different groups of individuals with mental health problems [63,64,70].

First, it seems that what is helpful in preventing (re)victimization varies across diagnostic groups. For instance, a group-based intervention combining emotion-regulation, conflict resolution, and street skills training, proved effective in preventing total victimization among individuals with dual diagnosis compared to care as usual. However, results for violent victimization were inconclusive, and substance abuse did not decrease [46]. Another intervention showed in individuals with depression a significant decrease in victimization incidents, suggesting that standard care such as psychotherapy and cognitive-behavioral therapy may be beneficial for this group [52]. Similarly, treating PTSD symptoms led to a reduction in revictimization among individuals with psychosis [42]. Moreover, our LCA revealed differences in victimization trajectories across diagnostic groups, underscoring the need to tailor interventions to specific subgroups of clients.

Furthermore, the complex nature of victimization, often involving familiar perpetrators, highlights the limitations of interventions solely focused on reducing victimization rates. Despite efforts to identify factors contributing to victimization, statistical models explain only a small proportion of the variance, suggesting that additional factors are at play [52]. Social support systems, including neighborhoods and social networks, can be protective factors [32,61,71]. It is evident that addressing victimization within the broader social context, including the neighborhood and social support networks, is crucial for effectively supporting individuals with SMI.

However, despite the high prevalence rates of victimization, it remains largely undetected and unaddressed in community mental health care settings. Addressing this issue requires guidance and support from mental health professionals and their management. Studies within the NWO program have shown that interventions addressing the impact of victimization on societal participation can contribute to individuals feeling acknowledged and supported in their recovery process. Educating mental health teams in managing domestic violence and abuse and implementing body-oriented resilience therapy are steps toward improving victimization recovery. In conclusion, mental health professionals should be equipped with the necessary skills and knowledge to support clients in acknowledging, addressing past victimization, and preventing future victimization.

Recent developments in mental health care highlight the need to integrate a positive risk approach within recovery-oriented practices

Since the start of this research project, the mental health care landscape has changed significantly. A recent report highlighted developments over the past 15 years, revealing challenges such as an increase of people with mental disorders, stagnant budgets, growing waiting lists, and a shortage of staff, all of which have strained specialized mental health care, including FACT [72,73]. Particularly, individuals with SMI, requiring comprehensive support and treatment for multifaceted issues, often have to wait too long for integrated care addressing their diverse needs. Historically, mental health care focused on treatment and clinical recovery [2]. Community mental health care has shifted towards supporting all aspects of recovery, including societal recovery. For instance, FACT teams have integrated employment and rehabilitation specialists [50]. Nevertheless, recent policy changes and the aforementioned challenges have forced FACT teams to adopt a more problem-oriented approach at the expense of rehabilitation [73].

Moreover, current practices often perceive recovery-oriented approaches and risk management as conflicting. Recovery focuses on connectedness, hope, and empowerment [74], while risk management prioritizes protection and avoiding risks [75]. However, mitigating risks for clients can inadvertently foster avoidance behaviors and social isolation. Our results illustrated these challenges. Professionals struggled to support clients with rehabilitation goals and address victimization experiences that hindered goal attainment, and connecting to the client's narrative. It also showed that by taking the time and having an inquisitive attitude, clients opened up more about their vulnerabilities, leading to enhanced insights into their rehabilitation needs and better support strategies. This suggests that managing risk and safety can complement individual recovery rather than hinder it.

Several studies offer valuable insights for integrating a positive risk approach into contemporary community mental health care. Repper and Perkins state: "If we are really to create services that are tailored around those whom we serve, our starting point cannot be 'the patient in our services'. Instead we must think about 'the person in their life'. We must start by understanding the challenges that people with mental health problems face in living their lives within and beyond limits imposed by the problems they face." [76(p.85)]. Similarly, Stuart et al. [77] propose incorporating the D for Difficulties into the CHIME (Connectedness, Hope, Identity, Meaning, Empowerment) framework to address challenges hindering recovery. Additionally, relational care, involving the client's network plays a crucial role in care outcomes [78]. Establishing an open, transparent, and empathetic relationship between clients and professionals is key, enabling clients to express their experiences and its impact, and professionals to acknowledge the associated pain and loss, but also to their perspective and constraints [75]. Related to this is including the client in treatment planning or shared decision making [79]. By moving away from a paternalistic approach towards a more collaborative approach, it creates room for self-determination and the perspectives on safety and risk [75,80]. What it also does is moving the sole responsibility for the client's safety away from the professionals and making the client accountable for their own decisions [15]. Ultimately, integrating a positive risk approach, balancing responsible risk-taking with ensuring safety and security, has the potential to reinforce current recovery-oriented care and broader outpatient mental health care.

A broader view on addressing the impact of victimization is needed
As discussed earlier, effective interventions for reducing victimization rates remain scarce, as evidenced the NWO program's mixed results. Furthermore, our findings (Chapter 5) showed no significant impact of the Victoria intervention on participation outcomes. Within the current mental health care system, it appears challenging to simultaneously prevent victimization and address its impact on societal recovery. Previous research, as well as the outcomes of this dissertation, highlights that individuals with SMI are often victimized by individuals in their close surroundings, such as family members, friends, neighbors, or roommates [81,82]. While we advocate for a personalized approach within community mental health care (supported by the LCA results), interventions focusing more explicitly on addressing the unsafe environment may hold promise in addressing victimization's impact and enhancing societal participation.

In the introduction of this dissertation, we highlighted several recent developments aimed at overcoming barriers to social participation, such as the Dutch 'Netwerkzorg' (network care) approach. This approach emphasizes interdisciplinary collaboration and working across domains, potentially facilitating better coping mechanisms for victimization. While not yet empirically validated, it incorporates effective principles such as peer support and the resource group method, both of which promote participation and mitigate victimization. Our process evaluation revealed that experts-by-experience found the Victoria intervention easier to implement compared to other mental health professionals. This is likely due to their ability to relate clients' experiences and maintain a more informal demeanor conducive to discussing sensitive topics like victimization. The resource group method, which integrates significant others into treatment, could be particularly helpful given that many perpetrators originate from the victim's close environment and the protective role social networks can play. This method, integrated into FACT teams, fosters empowerment, personal recovery, and social functioning, thereby providing a safe environment to discuss victimization experiences [53]. Additionally, providing integrated care and support could enhance social recovery [83,84], as both FACT teams and the social domain support individuals with participation and employ rehabilitation methods. This contrasts with the current fragmented and ineffective rehabilitation practices and highlights the potential benefits of a more cohesive approach [85].

Taking an even broader perspective at social inclusion, promoting safe participation aligns with the overarching concept of 'citizenship-oriented mental health care' [86]. Victimization's effects extend beyond the individual, impacting society as a whole. For instance, individuals with SMI face several barriers to employment, including employer hesitancy to hire individuals with psychiatric diagnoses and companies ill-equipped to accommodate them [87]. Public and structural stigma are still significant problems in present society and instigate self-stigma [57,88]. By promoting citizenship for individuals with SMI, this not only entails obligations as a true citizen, it also stresses "the need for building inclusive communities that support citizenship" [35(p.1)]. Rowe et al.'s [89,90] citizenship framework emphasizes the inclusion of people with mental illness and complex needs. He defines citizenship as a persons' connection to –he 5 Rs - rights, responsibilities, roles, resources, and relationships – and "a sense of belonging in one's community and society both supports and is supported by a strong connection to the 5 Rs. This sense of belonging must be validated by others' recognition of one's valued membership in society" [90(p.17)]. While the current recovery perspective emphasizes personal growth, the citizenship framework adopts a broader societal perspective, focusing on the requirements for full participation in society [90]. Incorporating this perspective can empower mental health care to not only support clients within their networks but also to address and diminish barriers to community inclusion [35,91-93].

Further recommendations for future research

Acquiring more insight in the working elements

Our findings suggest that addressing victimization experiences can be beneficial, particularly in terms of acknowledgement and support during recovery. However, some questions remain regarding the effectiveness, completeness and quality of the intervention and its specific working elements. It should be explored whether further specifying the client's demoralization, such as identifying the specific participation domain and victimization incident, would enhance effectiveness. Additionally, integrating more guidance on follow-up steps could be valuable. It is unclear whether the intervention would be more effective with better application, improved support or training for professionals, or if additional interventions are required to address victimization comprehensively. Moreover, longer follow-up periods in studies may be necessary due to the lower occurrence rate of victimization incidents, making it challenging to measure change over shorter periods. The intervention also necessitates a certain change in the professional's attitudes with regard to the safety of addressing victimization experiences and the required 'sit on their hands' stance, which requires time for adoption. Developing a fidelity instrument to measure adherence to the intervention model is recommended. This would help identify if better application leads to improved outcomes [94,95]. Additionally, studies on the effectiveness of the Victoria intervention as an add-on to other existing effective interventions, such as the resource group method or network intake, are needed. Lastly, participatory action research can facilitate sustainable implementation of the intervention and provide deeper insights into its working elements. This approach would involve collaboration between researchers, mental health professionals, and clients with SMI to refine the intervention.

Unravel the link between victimization, discrimination, and societal participation

Numerous studies established the consequences of both victimization and discrimination [14,58,96-98]. However, our findings, as discussed in Chapter 5, presented counterintuitive results regarding the impact of addressing victimization on anticipated stigmatization and experienced discrimination. Future research should delve deeper into the unique dynamics of victimization, discrimination, perpetration, and societal participation for different subgroups identified in Chapter 2. This can help tailor support strategies. Furthermore, it is essential to recognize that social inclusion encompasses various subdomains, including employment, social support, and neighborhood inclusion, with each being influenced differently by victimization in different individuals. Furthermore, demoralization may manifest even in the absence of victimization [99]. Understanding which individuals are negatively impacted, the specific participation domains affected, and more importantly, identifying those who are resilient to anticipated stigmatization and victimization can provide valuable insights for targeted support. Protective factors such as guardianship or social support play a significant role in this regard [71,100]. Additionally, given the high prevalence of intellectual disability (ID) within mental health care, it is crucial to explore their specific experiences with victimization and discrimination. Research suggest that people with ID are more susceptible to abuse and exploitation [101]. However, their experiences, including the impact on different participation domains, remain under-investigated. Qualitative studies can complement quantitative research to gain a deeper understanding of subjective experiences and meanings associated with victimization and inform interventions that promote social inclusion and protect this vulnerable population.

Inclusion of neighborhood factors in victimization research among individuals with SMI

The deinstitutionalization of mental health care necessitates a stronger focus on neighborhood factors in future victimization research. The inclusion of individuals with SMI cannot be seen outside the community in which they reside and participate [37,38], aligning with the citizen framework previously mentioned [90]. Victimology, criminology, and sociology offer valuable insights through established theories like social disorganization and social capital, which explore how interpersonal connections and community involvement can protect individuals from negative experiences and disadvantage [102-104]. Future studies should incorporate insights from these theories. The concept of 'collective efficacy', derived from Bandura et al.'s self-efficacy concept [105], refers to "social cohesion among neighbors combined with their willingness to intervene on behalf of the common good" [106(p.918)], and is particularly relevant. Research suggests that strong collective efficacy can be a promising factor in reducing vulnerability to violent victimization [107,108]. Future research should explore whether safe and cohesive neighborhoods function similarly for individuals with SMI, potentially lowering their risk of victimization. Collective efficacy goes beyond social cohesion. It involves a willingness of community members to take action together. This requires acceptance of individuals with SMI, which can be fostered through education and outreach programs. Future research should assess whether safe and cohesive neighborhoods function as protective factors for individuals with SMI.

Conclusion

Despite ongoing efforts to integrate individuals with SMI into society, with growing evidence that recovery is more frequent and realistic than was assumed so far, their level of societal participation remains significantly lower compared to the rest of the population [3-5,25,109,110]. Stigma, discrimination, and victimization are just some of the obstacles and risks hindering their participation. This dissertation sheds light on the complex interplay between victimization, discrimination, perpetration, and societal participation within different subgroups of individuals with SMI. Regrettably, these challenges are often inadequately addressed in routine treatment and support, even after training in specific interventions. The Victoria intervention, the first to incorporate dignity of risk principles into the FACT and rehabilitation approaches, has shown initial promise. It fosters a sense of acknowledgement of victimization experiences and support in their recovery process. However, mental health professionals require better preparation and support to effectively address the impact of victimization experiences while navigating the delicate balance between ensuring safety and empowering individuals to take responsible risks. Further research is urgently needed to explore effective strategies, including incorporating neighborhood factors to address these challenges and promote greater social inclusion of people with severe mental health problems.

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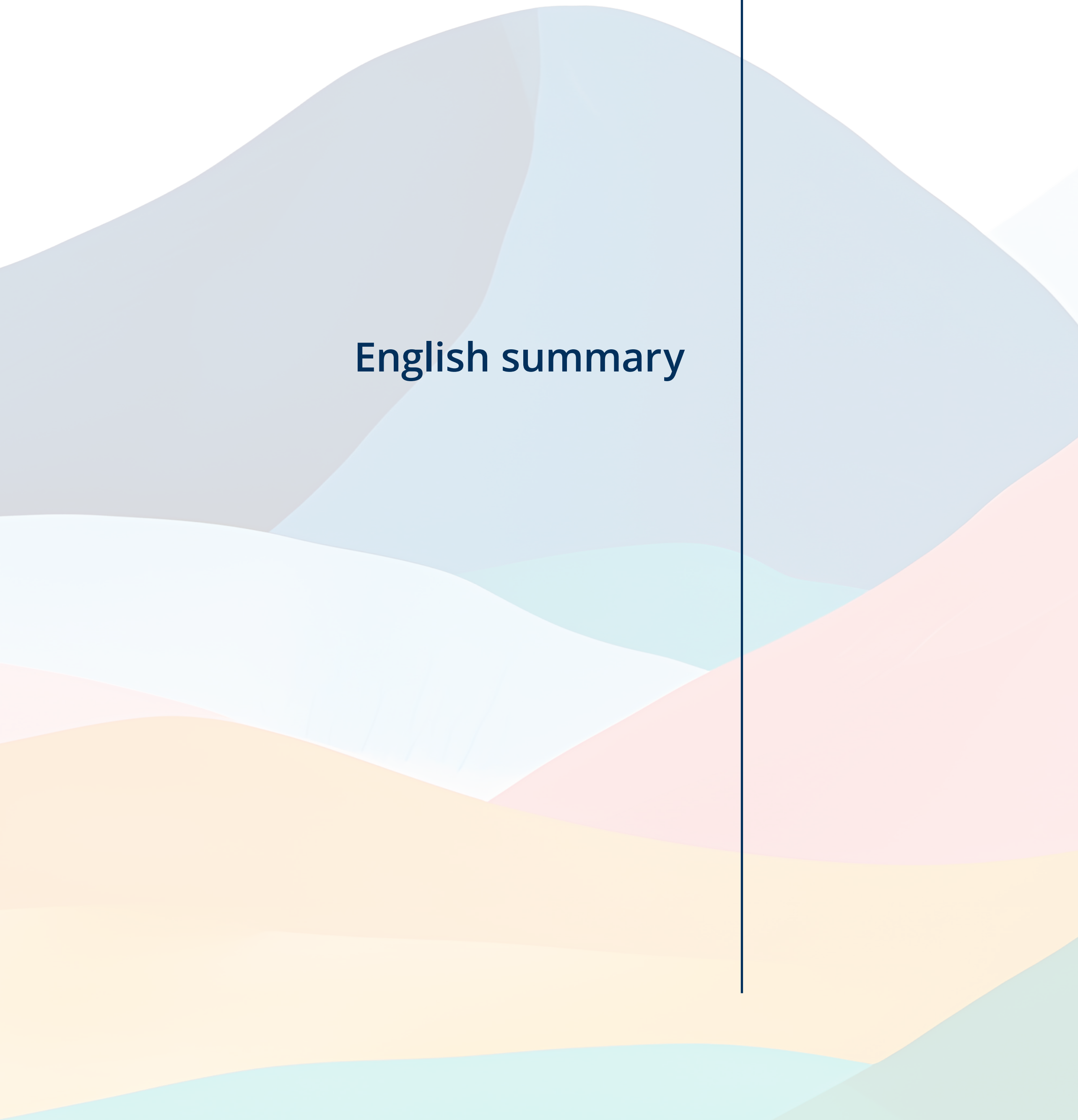
English summary



General introduction (Chapter 1)

Mental illnesses are prevalent in the Netherlands, with nearly half of the adult population experiencing them at some point in their lives. Individuals for whom the mental illness persists and seriously influences their functioning (or the other way around) represent approximately 1.5% of the Dutch population and are referred to as having a severe mental illness (SMI) in this thesis. Many face financial challenges, including unemployment, reliance on social benefits, and strained social relationships, all of which are essential for recovery.

Just like anyone else, individuals with enduring mental health problems yearn for social connections, a sense of belonging, and meaningful activities. Societal participation, including employment, relationships, and community involvement, is crucial for building resilience and improving quality of life.

However, despite rehabilitation efforts, individuals with SMI often face significant barriers to participating in society. Employment rates among people with SMI are low, and their social networks are typically smaller. Additionally, they spend less time in meaningful activities. While effective interventions exist, such as Individual Placement and Support (IPS) and Housing First, they are not always widely available. Moreover, there is limited evidence for interventions that address social isolation or help individuals retain social roles. Research is needed to develop interventions that can tackle the broader issues of societal participation for individuals with SMI.

Stigma and discrimination are two of the most significant barriers preventing individuals with SMI from fully participating in society. Stigma involves attaching negative labels to mental illness, leading to discriminatory behaviors. Many individuals with SMI internalize these stereotypes, leading to self-stigma. Research consistently shows that people with SMI experience high levels of stigma and discrimination.

Victimization is another major issue for people with SMI. Individuals with SMI are victimized at much higher rates than the rest of the population. Several factors contribute to these high victimization rates, including homelessness, substance abuse, and adverse childhood experiences.

Both stigma and victimization have far-reaching effects on societal participation for individuals with SMI. Stigma, particularly when internalized, leads to demoralization and a decreased willingness to engage in social and professional activities, a phenomenon known as the “why try” effect. Victimization, on the other hand, damages trust in others and increases social isolation, as individuals may withdraw from social interactions due to fear or trauma. These experiences negatively influence self-efficacy, making it harder for individuals with SMI to build and maintain social relationships or engage in meaningful activities. Only two studies have simultaneously examined the impact of both victimization and discrimination on societal participation. These studies suggest that victimization, particularly in people with schizophrenia spectrum disorders, leads to negative self-esteem and social withdrawal through self-stigma and discrimination, highlighting the potential of targeted interventions to improve societal participation.

Flexible Assertive Community Treatment (FACT) teams, part of the current community-based care system, provide continuous, multidisciplinary care tailored to various life domains. They adapt support during stable periods and times of crisis. While the model has successfully reduced hospital readmissions, it has not fostered societal participation and recovery as intended. The Boston University Approach to Psychiatric Rehabilitation (BPR) is a widely used method within FACT. It promotes autonomy, personal growth, and achieving life goals. However, its effectiveness in promoting societal participation is mixed.

Many individuals with SMI encounter life challenges, including high levels of victimization, which however, have been studied rarely as a serious explanatory variable for the low levels of participation. FACT and BPR, while offering tools for supporting societal participation, lack specific approaches to address the impact of victimization. Discussing the impact of victimization has been shown to aid recovery without increasing trauma. The concept of "dignity of risk" encourages responsible risk-taking. This approach, while underexplored in community mental health care, can empower individuals with SMI. There is a need for more interventions that balance safety with promoting clients' self-determination and societal integration.

The aim of this dissertation is twofold. The first aim is to gain insight in the variation in victimization, perpetration, experienced discrimination, and social functioning rates among individuals with SMI. The second aim is to develop and evaluate a victimization-informed intervention, assessing both its implementation process and effectiveness in reducing victimization, enhancing recognition and coping mechanisms, and consequently fostering societal participation.

Results (Chapters 2-6)

To gain more insight into patterns of victimization in daily life and their relationship with societal participation, **Chapter 2** investigates whether conceptually cohesive profiles exist among outpatients with SMI. These profiles are based on experiences of victimization, perpetration, discrimination, stigmatization, and societal participation. A latent class analysis was conducted on 395 individuals with SMI treated in FACT teams, using baseline data from a cluster randomized controlled trial (RCT). Additionally, differences between the subgroups were examined.

The results showed that three subgroups were identified. The first group experienced the lowest number of victimization incidents (25%, vs. 18% of the general population in 2015) and were (almost) never a perpetrator of an incident. This group was labelled the *"General Difficultie*s class" (28.8% of participants). In this class, more individuals had schizophrenia or other psychotic disorders than in the other two classes. The second class had a higher prevalence rate of experienced discrimination than the first class, and this group felt they had the least skills in coping with discrimination. This class is labelled the *"Discriminated and Avoidin*g class" (36.8% of participants). Individuals in this class undertook the least pro-social activities and experienced the least social support from their environment. The third class had the highest prevalence of victimization and perpetration, and also had the highest scores for experienced discrimination and anticipated stigmatization. Therefore, this class was labelled the *"Victimized and Perpetratin*g class" (34.4% of participants), and was further characterized by problems in multiple domains, such as psychosocial functioning, self-efficacy, and quality of life.

These subgroups underline the need for a more individualized approach in rehabilitation trajectories for outpatients with SMI, with distinctive approaches and support needed for each class. Furthermore, more focus is needed on the impact of difficulties in the client's social context to adequately support them in the rehabilitation process.

The iterative process of the development and pilot of the Victoria intervention is elaborately outlined in **Chapter 3**. A review of the relevant literature provided several directions for intervention strategies. To address the impact of victimization on societal participation, a future intervention will focus on: prioritizing empowerment while addressing demoralization; exploring the underlying reasons for demoralization to remove barriers to inclusion; adopting a more person-centered approach in rehabilitation, emphasizing empathy and connection; incorporating the concept of "dignity of risk", allowing individuals with SMI to take calculated risks for personal growth; and, promoting shared decision-making between clients and professionals to foster autonomy and empowerment.

In the first development phase, intervention components were identified through two focus groups, consisting of individuals with varying professional expertise. Results of these focus groups were translated into a first draft of the intervention in several expert meetings. In the second phase, the first version of the intervention was then piloted in two outpatient teams, and professionals were interviewed about their experiences. In the third phase, the intervention was finalized through expert meetings and feedback from workshops held at international conferences.

The final result was an intervention which supports professionals to address victimization and its consequences, in order to reinforce safe societal participation and improve recovery. The Victoria intervention includes positive risk management, focusing on clients' narratives and strengths, and awareness of unsafe (home) environments: it comprises four steps: exploring issues with societal participation, analyzing victimization experiences, clarifying the context of these experiences, and determining future steps, including victimization-sensitive rehabilitation planning and optional trauma treatment.

To investigate whether the Victoria intervention would be an effective intervention to improve societal participation and decrease victimization of individuals with SMI, a cluster randomized controlled trial and a process evaluation were designed and conducted. In **Chapter 4**, the design and methods of the trial are outlined. The study was designed as a multisite cluster RCT, in which eight teams would be randomly allocated to the experimental or care as usual condition. All teams received an update in rehabilitation methods, and four teams were trained in the Victoria method.

Chapter 5 presents the results of a multicenter cluster RCT to evaluate the effectiveness of the Victoria intervention. Designed to manage and prevent re-victimization and support safe participation by acknowledging the impact of victimization experiences, the intervention was implemented among 400 clients (216 in the intervention group and 184 in the control group) at Parnassia Psychiatric Institute (formerly Dijk and Duin) and GGzE. Linear mixed models and generalized estimating equations showed an increase in both groups in terms of experienced discrimination, anticipated discrimination, and self-efficacy. In the last follow-up measurement, having Victoria conversations had a moderating effect on the found increase in experienced discrimination, and the clients felt significantly more acknowledged and supported in their recovery process. We found no significant effects on the primary outcomes victimization and societal participation and other secondary outcomes.

While the intervention did not reduce victimization, it did increase awareness of discrimination in both intervention and control groups. This increased awareness might have led to the observed increase in reported discrimination. However, the intervention was found to moderate the impact of this increase, suggesting its potential to help clients cope with discrimination. The lack of intervention effects on societal participation and victimization could be attributed to factors such as the high levels of social functioning and victimization among participants, low scores on rehabilitation items, and the challenges of measuring changes in criminal victimization. Despite implementation difficulties, the Victoria intervention demonstrated potential benefits in enhancing clients' sense of acknowledgment and support. Addressing victimization experiences, even without formal trauma treatment, can be a valuable component of recovery-oriented care.

Chapter 6 presents a process evaluation to better understand the trial effects. The implementation process, including training, usage, influencing factors, and client impact, was examined using a mixed-methods design. Data sources included treatment plans (*n* = 66), usage checklists (*n* = 20), observations of intervision sessions (*n* = 25), structured questionnaires (*n* = 215), and semi-structured interviews (*n* = 34) with clients and professionals.

Results indicated that while participants acknowledged the importance of discussing victimization, treatment plans often did not fully adhere to rehabilitation principles. Despite positive perceptions of the intervention, factors such as heavy caseloads, limited time, and organizational barriers hindered its consistent use. Professionals recognized the importance of addressing victimization and discrimination but were often hesitant to fully follow intervention steps, fearing that clients might relapse or feel uncomfortable. However, when discussions were initiated, professionals reported positive outcomes, with clients feeling acknowledged and supported. Few clients said that victimization was placed on the agenda, however, when it was, they felt acknowledged and supported.

While professionals claimed to have used the intervention, interviews revealed a more flexible and hesitant application. This suggests a need for more specific training, particularly in addressing difficult conversations about demoralization and adversity. Experts-by-experience, with their strengths-based focus and personal experiences, were more comfortable with the approach. Stricter adherence to the intervention and its integration into treatment plans could enhance its impact.

General discussion (Chapter 7)

Finally, **Chapter 7** offers a reflection on the main findings, including methodological considerations, practical implications, and recommendations for future research. Four main themes are discussed.

First, the study provides insights into the complex relationship between victimization and societal participation. While victimization can hinder societal participation, some individuals manage to maintain social functioning despite high victimization rates. However, these individuals often face challenges in other areas, such as psychosocial functioning and self-efficacy. The study emphasizes the need to consider multiple aspects of participation (e.g., employment, social engagement, neighborhood cohesion) and to understand the role of community dynamics. Mental health professionals must balance managing risks associated with social involvement with supporting recovery, adhering to the principle of “dignity of risk”.

Second, implementing the Victoria intervention in daily mental health practice presented challenges. Despite efforts from all participants, several key issues emerged. Professionals were hesitant to initiate victimization discussions, fearing negative consequences for clients. The intervention’s focus often shifted from societal participation to generalized victimization, hindering its application. While professionals became aware of victimization and applied initial steps, adherence to the full intervention sequence was inconsistent. Additionally, low adherence to rehabilitation methods like the BPR and a focus on daily concerns limited the intervention's impact.

Third, the intervention's impact on societal participation was limited. The hypothesis that addressing victimization and discrimination would improve societal participation was not confirmed. This suggests that societal participation is more complex and challenging, even for well-trained teams. Moreover, improving societal participation and decreasing stigma and discrimination takes more than a single intervention. Additionally, the intervention's focus on recognizing and acknowledging victimization, even though important, may not have directly addressed the client's barriers to participation. Full implementation requires time, regular reassessment, and follow-up actions. Additionally, crisis management pressures hamper rehabilitation efforts, pointing to the need for a more structured and positive risk approach in future interventions.

Fourth, the intervention's impact on victimization, stigmatization, and discrimination was mixed. Clients who engaged in Victoria conversations showed no significant changes in victimization. A possible reason is that the intervention did not target neighborhood factors that influence victimization risk, which future research could explore. While anticipated stigmatization and experienced discrimination increased over time in both groups, a mitigating effect was seen for discrimination in the intervention group. This aligns with research suggesting that discrimination and stigmatization are distinct concepts influenced by different social and psychological factors. The intervention's positive impact on discrimination might be linked to improved social skills and resilience, highlighting the need for further research on the complex interplay with societal participation.

Several methodological considerations regarding the study design and research process of the Victoria intervention were discussed. The intervention aims for mental health professionals to adopt a positive risk approach, requiring a cultural shift that may take longer than the study's duration allowed. While initial results from the RCT showed promise in recognizing and acknowledging victimization experiences, they did not lead to decreased victimization or increased societal participation. The study's follow-up period of 20 months may have been insufficient for observing significant behavioral changes.

Examining the intervention's implementation alongside the RCT provided valuable insights into contextual factors and client responses, but challenges arose from training professionals to use the intervention indirectly and its inherent flexibility, which complicated the measurement of its effects. Achieving standardization was not feasible for the Victoria intervention, as tailoring to the client's needs was an essential part of the intervention.

The study underscores the importance of a well-developed implementation strategy, suggesting that an implementation plan could have enhanced delivery and offered insights into necessary changes in knowledge, attitude, and behavior. Contextual factors were evaluated post-implementation, while anticipating on preliminary contextual factors could have improved outcomes.

A full feasibility study prior to the intervention's testing would have been beneficial to identify barriers and enhance sustainability, as professionals struggled to integrate the intervention into daily practice.

Overall, the intervention would benefit from further refinement before broader testing, with recommendations for more focused guidance on participation domains, the nature of victimization incidents, and follow-up steps.

This dissertation highlights the challenges in addressing victimization among individuals with mental illness. While interventions can increase awareness, they often have limited impact on reducing victimization or enhancing societal participation. There are several implications for future interventions.

First, mental health professionals need to be better equipped to support clients dealing with victimization experiences, including the impact on their lives. The ten-year program "Violence against Psychiatric Patients", including this dissertation provide several insights. First, future interventions should be tailored to specific client subgroups. Second, as victimization often involves familiar perpetrators, this requires broader interventions than just reducing victimization rates, by including social context. Third, many victimization incidents remain undetected, needing comprehensive support from mental health professionals. They should be equipped with the necessary skills and knowledge to support clients in acknowledging, addressing past victimization, and preventing future victimization.

Second, recent developments in mental health care highlight the need to integrate a positive risk approach within recovery-oriented practices. Challenges include increased demand, limited resources, and a shift towards problem-oriented approaches. This can lead to a conflict between recovery-oriented practices and risk management. To effectively integrate a positive risk approach into rehabilitation, several strategies are recommended: shifting the focus from "the patient" to "the person in their life", involving the clients network, and promoting a collaborative approach that emphasizes self-determination and creates room for safety and risk.

Third, a broader view is needed to address the impact of victimization. Recent developments, such as the Dutch "Netwerkzorg" (network care) approach, emphasize interdisciplinary collaboration to improve coping mechanisms for victimization, incorporating effective principles like peer support and resource groups. Integrating resource groups into FACT teams could foster empowerment and provide safe spaces for discussing victimization. Providing integrated care can enhance social recovery by supporting participation and rehabilitation, moving away from fragmented practices. Promoting safe participation aligns with "citizenship-oriented mental health care", which recognizes the societal impact of victimization and emphasizes building inclusive communities. Incorporating this broader societal perspective can empower mental health care to not only support clients within their networks but also to address and diminish barriers to community inclusion.

Addressing victimization experiences is beneficial, but further research is needed to evaluate the effectiveness and quality of the intervention. Future studies should specify client demoralization by identifying participation domains and victimization incidents. Additional guidance on follow-up steps and professional training may enhance outcomes. Longer follow-up periods are necessary to measure change effectively, given the low occurrence rates of victimization incidents. Developing a fidelity instrument to assess adherence to the intervention model is recommended. Research should also explore the Victoria intervention as an add-on to existing interventions like the resource group method or network intake. Participatory action research can also enhance sustainable implementation and gain deeper insights into the intervention's mechanisms.

Future research should examine the complex dynamics between victimization, discrimination, and societal participation across different subgroups. Understanding how victimization influences domains like employment and social support is crucial. Identifying resilient individuals and protective factors, such as social support, can inform targeted support strategies. Given the high prevalence of intellectual disabilities within mental health care, it is essential to explore their unique experiences with victimization and discrimination, as these are often under-researched. Qualitative studies can complement quantitative findings by providing deeper insights into subjective experiences related to victimization.

Future research should investigate neighborhood factors in the context of victimization among individuals with SMI. Theories from victimology, criminology, and sociology, such as social disorganization and social capital, can provide valuable insights into how community involvement protects against victimization. Studies should assess whether cohesive neighborhoods act as protective factors and explore how education and outreach programs can promote acceptance of individuals with SMI.

Despite efforts to integrate individuals with SMI into society, their societal participation remains significantly lower than that of the general population due to stigma, discrimination, and victimization. This dissertation examines the complex relationships among victimization, discrimination, and societal participation in various subgroups with SMI. These challenges are often inadequately addressed in routine treatment, even after specific training. The Victoria intervention, which incorporates “dignity of risk” principles into FACT and rehabilitation approaches, shows promise in acknowledging victimization and supporting recovery. However, mental health professionals need improved preparation to navigate the balance between ensuring safety and empowering individuals. Further research is urgently needed to identify effective strategies, including neighborhood factors, to enhance social inclusion for individuals with severe mental health problems.

9

Samenvatting (Summary in Dutch)

Introductie (Hoofdstuk 1)

In Nederland komt psychische problematiek veel voor. Bijna de helft van de volwassen bevolking ervaart op een bepaald moment in hun leven psychische klachten. Personen bij wie de psychische stoornis aanhoudt en ernstig van invloed is op hun functioneren (of andersom) vormen ongeveer 1,5% van de Nederlandse bevolking en worden in dit proefschrift aangeduid als mensen met een ernstige psychische aandoening (EPA). Velen kampen met financiële problemen, zoals werkloosheid, afhankelijkheid van sociale uitkeringen en een verstoord sociaal netwerk, die allemaal essentieel zijn voor herstel.

Net als iedereen verlangen mensen met langdurige psychische problemen naar sociale verbindingen, het gevoel erbij te horen en zinvolle activiteiten. Maatschappelijke participatie, inclusief werk, relaties en betrokkenheid bij de gemeenschap, is cruciaal voor het opbouwen van veerkracht en het verbeteren van de kwaliteit van leven.

Echter, ondanks rehabilitatie-inspanningen, ervaren mensen met een EPA vaak aanzienlijke belemmeringen in hun maatschappelijke participatie. De arbeidsparticipatie onder mensen met een EPA is laag en hun sociale netwerken zijn doorgaans kleiner. Bovendien besteden ze minder tijd aan zinvolle activiteiten. Hoewel er effectieve interventies bestaan, zoals Individual Placement and Support (IPS) en Housing First, zijn deze niet altijd op grote schaal beschikbaar. Bovendien is er beperkt bewijs voor interventies die zich richten op sociale isolatie of mensen helpen sociale rollen te behouden. Er is onderzoek nodig om interventies te ontwikkelen die de bredere kwesties van maatschappelijke participatie voor mensen met EPA kunnen aanpakken.

Stigma en discriminatie zijn twee van de belangrijkste belemmeringen voor mensen met EPA om volledig deel te nemen aan de samenleving. Stigmatisering houdt in dat er negatieve labels aan psychische aandoeningen worden gehangen, wat leidt tot discriminerend gedrag. Veel mensen met EPA internaliseren deze stereotypen, wat leidt tot zelfstigma. Onderzoek toont consistent aan dat mensen met EPA hoge niveaus van stigma en discriminatie ervaren.

Slachtofferschap is een ander belangrijk probleem voor mensen met EPA. Mensen met EPA worden veel vaker het slachtoffer dan de rest van de bevolking. Verschillende factoren dragen bij tot deze hoge cijfers, waaronder dakloosheid, middelenmisbruik en negatieve ervaringen uit de kindertijd.

Zowel stigmatisering als slachtofferschap hebben verstrekkende gevolgen voor de maatschappelijke participatie van mensen met EPA. Stigma, vooral wanneer het geïnternaliseerd is, leidt tot ontmoediging en een verminderde bereidheid om deel te nemen aan sociale en professionele activiteiten, een fenomeen dat bekend staat als het “why try” effect. Slachtofferschap daarentegen schaadt het vertrouwen in anderen en vergroot sociaal isolement, omdat mensen zich kunnen terugtrekken uit sociale interacties als gevolg van angst of trauma. Deze ervaringen hebben een negatieve invloed op de zelfredzaamheid, waardoor het voor mensen met EPA moeilijker wordt om sociale relaties op te bouwen en te onderhouden of zich bezig te houden met zinvolle activiteiten. Slechts twee studies hebben tegelijkertijd de impact van zowel slachtofferschap als discriminatie op maatschappelijke participatie onderzocht. Deze studies suggereren dat slachtofferschap, in het bijzonder bij mensen met schizofreniespectrumstoornissen, leidt tot een negatief gevoel van eigenwaarde en sociale terugtrekking door zelfstigma en discriminatie.

Flexible Assertive Community Treatment (FACT) teams, onderdeel van de ambulante geestelijke gezondheidszorg (ggz), bieden continue en multidisciplinaire zorg die is afgestemd op verschillende levensdomeinen. Ze passen de ondersteuning aan tijdens stabiele periodes en tijden van crisis. Hoewel het model met succes het aantal heropnames in ziekenhuizen heeft teruggedrongen, heeft het niet de beoogde maatschappelijke participatie en herstel bevorderd. De Individuele Rehabilitatie Benadering (IRB) is een veelgebruikte methode binnen FACT. Het bevordert autonomie, persoonlijke groei en het bereiken van levensdoelen. De effectiviteit in het bevorderen van maatschappelijke participatie is echter wisselend.

Veel mensen met EPA hebben te maken met uitdagingen in het leven, waaronder een hoge mate van slachtofferschap, die echter zelden zijn onderzocht als een belangrijke verklarende variabele voor de lage participatieniveaus. FACT en de IRB bieden weliswaar hulpmiddelen om maatschappelijke participatie te ondersteunen, maar missen specifieke benaderingen om de impact van slachtofferschap aan te pakken. Het is aangetoond dat het bespreken van de impact van slachtofferschap het herstel bevordert zonder het trauma te verergeren. Het concept ‘dignity of risk’ moedigt het nemen van verantwoorde risico’s aan. Deze benadering, die nog onvoldoende onderzocht is in de ggz, kan mensen met EPA weerbaarder maken. Er is behoefte aan meer interventies die ondersteunen bij het vinden van een balans in risico’s nemen en veiligheid bij participatie in de samenleving.

Het doel van dit proefschrift is tweeledig. Het eerste doel is om inzicht te krijgen in de variatie in slachtofferschap, daderschap, ervaren discriminatie en sociaal functioneren onder mensen met EPA. Het tweede doel is het ontwikkelen en evalueren van zowel het implementatieproces als de effectiviteit van een op slachtofferschap gerichte interventie, die gericht is op het verminderen van slachtofferschap, het verbeteren van erkenning en copingmechanismen, en dientengevolge het bevorderen van maatschappelijke participatie.

Resultaten (hoofdstukken 2-6)

Om meer inzicht te krijgen in patronen van slachtofferschap in het dagelijks leven en hun relatie met maatschappelijke participatie, onderzoekt **hoofdstuk 2** of er conceptueel samenhangende profielen bestaan onder mensen met EPA die ambulante zorg ontvangen. Deze profielen zijn gebaseerd op ervaringen van slachtofferschap, daderschap, discriminatie, stigmatisering en maatschappelijke participatie. Er werd een latente klassenanalyse uitgevoerd op 395 personen met EPA die werden behandeld in FACT-teams, waarbij gebruik werd gemaakt van baselinegegevens van een cluster randomized controlled trial (RCT). Daarnaast werden verschillen tussen de subgroepen onderzocht.

Uit de resultaten bleek dat er drie subgroepen werden geïdentificeerd. De eerste groep had het laagste aantal slachtofferschapincidenten (25%, vs. 18% van de algemene bevolking in 2015) en was (bijna) nooit dader van een incident. Deze groep kreeg het label *Algemene Moeilijkheden* (28,8% van de deelnemers). In deze klasse hadden meer personen schizofrenie of andere psychotische stoornissen dan in de andere twee klassen. De tweede groep ervoer meer discriminatie dan de eerste groep, en deze groep vond dat ze de minste vaardigheden hadden om met discriminatie om te gaan. Deze klasse wordt de *Gediscrimineerde en Vermijdende* klasse genoemd (36,8% van de deelnemers). Individuen in deze klasse ondernamen de minste sociale activiteiten en ondervonden de minste sociale steun uit hun omgeving. De derde klasse had het hoogste aantal slachtofferschap en daderschap incidenten, en scoorde ook het hoogst op ervaren discriminatie en verwachte stigmatisering. Deze klasse werd daarom de *Slachtoffer- en Dader*klasse genoemd (34,4% van de deelnemers) en werd verder gekenmerkt door problemen op andere domeinen, zoals psychosociaal functioneren, zelfredzaamheid en kwaliteit van leven.

Deze subgroepen onderstrepen de noodzaak van een meer geïndividualiseerde aanpak in rehabilitatietrajecten voor ambulante cliënten met EPA, waarbij voor elke klasse een andere aanpak en ondersteuning nodig is. Verder is er meer aandacht nodig voor de impact van moeilijkheden in de sociale context van de cliënt om hen adequaat te ondersteunen in het rehabilitatieproces.

Het iteratieve proces van de ontwikkeling en pilot van de Victoria-interventie wordt uitgebreid beschreven in **hoofdstuk 3**. Een overzicht van de relevante literatuur leverde verschillende richtingen op voor interventiestrategieën. Om de impact van slachtofferschap op maatschappelijke participatie aan te pakken, zal een toekomstige interventie zich richten op: het geven van prioriteit aan empowerment terwijl ontmoediging wordt aangepakt; het onderzoeken van de onderliggende redenen voor ontmoediging om barrières voor inclusie weg te nemen; het aannemen van een meer persoonsgerichte benadering in rehabilitatie, met nadruk op empathie en verbinding; het opnemen van het concept van 'dignity of risk', waardoor mensen met EPA berekende risico's kunnen nemen voor persoonlijke groei; en het bevorderen van gedeelde besluitvorming tussen cliënten en professionals om autonomie en empowerment te bevorderen.

In de eerste ontwikkelingsfase werden interventiecomponenten geïdentificeerd door middel van twee focusgroepen, bestaande uit personen met verschillende professionele expertise. De resultaten van deze focusgroepen werden tijdens verschillende expertmeetings vertaald naar een eerste concept van de interventie. In de tweede fase werd de eerste versie van de interventie getest in twee ambulante teams en werden professionals geïnterviewd over hun ervaringen. In de derde fase werd de interventie definitief gemaakt door middel van bijeenkomsten met experts en feedback van workshops die tijdens internationale conferenties werden gehouden.

Het eindresultaat was een interventie die professionals ondersteunt bij het bespreekbaar maken van slachtofferschap en de gevolgen daarvan, om veilige maatschappelijke participatie en herstel te bevorderen. De Victoria-interventie omvat positief risicomanagement, focust op het verhaal en de sterke kanten van cliënten, en bewustwording van onveilige (thuis)omgevingen: het bestaat uit vier stappen: problemen met maatschappelijke participatie onderzoeken, slachtofferschap-ervaringen analyseren, de context van deze ervaringen verduidelijken, en toekomstige stappen bepalen, waaronder slachtofferschap gerichte rehabilitatie en optionele traumabehandeling.

Om te onderzoeken of de Victoria-interventie een effectieve interventie zou zijn om maatschappelijke participatie te verbeteren en slachtofferschap van mensen met EPA te verminderen, werden een cluster gerandomiseerde gecontroleerde trial en een procesevaluatie ontworpen en uitgevoerd. In **hoofdstuk 4** worden de opzet en de methoden van het onderzoek beschreven. Het onderzoek werd opgezet als een multisite cluster-RCT, waarin acht teams willekeurig werden toegewezen aan de experimentele of gebruikelijke zorgconditie. Alle teams kregen een update in rehabilitatiemethoden en vier teams werden getraind in de Victoria-methode.

Hoofdstuk 5 presenteert de resultaten van een multicenter cluster-RCT om de effectiviteit van de Victoria-interventie te evalueren. De interventie, ontworpen om her-slachtofferschap te beheersen en te voorkomen en veilige participatie te ondersteunen door de impact van slachtofferschap-ervaringen te erkennen, werd geïmplementeerd bij 400 cliënten (216 in de interventiegroep en 184 in de controlegroep) van Parnassia (voorheen Dijk en Duin) en GGzE. 'Linear mixed models' en 'generalized estimating equations' lieten in beide groepen een toename zien in ervaren discriminatie, geanticipeerde discriminatie en empowerment. Bij de laatste follow-up meting had het voeren van Victoria gesprekken een matigend effect op de gevonden toename in ervaren discriminatie, en voelden de cliënten zich significant meer erkend en gesteund in hun herstelproces. We vonden geen significante effecten op de primaire uitkomsten slachtofferschap en maatschappelijke participatie en andere secundaire uitkomsten.

Hoewel de interventie het aantal gevallen van slachtofferschap niet verminderde, werd men zich wel meer bewust van discriminatie, zowel in de interventie- als in de controlegroep. Dit toegenomen bewustzijn kan hebben geleid tot de waargenomen toename in gerapporteerde discriminatie. De interventie bleek het effect van deze toename echter te matigen, wat suggereert dat de interventie cliënten kan helpen om te gaan met discriminatie. Het gebrek aan interventie-effecten op maatschappelijke participatie en slachtofferschap zou toegeschreven kunnen worden aan factoren zoals de hoge niveaus van sociaal functioneren en slachtofferschap onder de deelnemers, de lage scores op rehabilitatie-items en de uitdagingen bij het meten van veranderingen in slachtofferschap. Ondanks problemen bij de implementatie toonde de Victoria-interventie potentiële voordelen in het vergroten van het gevoel van erkenning en steun bij cliënten. Het aanpakken van slachtofferschap-ervaringen, zelfs zonder formele traumabehandeling, kan een waardevol onderdeel zijn van herstelgerichte zorg.

Hoofdstuk 6 presenteert een procesevaluatie om de effecten van de RCT beter te begrijpen. Het implementatieproces, inclusief training, gebruik, beïnvloedende factoren en impact op de cliënt, werd onderzocht met behulp van een mixed-methods design. Gegevensbronnen waren behandelplannen (*n* = 66), checklists (*n* = 20), observaties van intervisiesessies (*n* = 25), gestructureerde vragenlijsten (*n* = 215) en semigestructureerde interviews (*n* = 34) met cliënten en professionals.

De resultaten gaven aan dat de deelnemers het belang van het bespreken van slachtofferschap erkenden, maar dat de behandelplannen vaak niet volledig in overeenstemming waren met de rehabilitatieprincipes. Ondanks de positieve perceptie van de interventie, stonden factoren als een hoge werkdruk, beperkte tijd en organisatorische belemmeringen een consequent gebruik in de weg. Professionals erkenden het belang van het aanpakken van slachtofferschap en discriminatie, maar aarzelden vaak om de interventiestappen volledig te volgen uit angst dat cliënten zouden terugvallen of zich ongemakkelijk zouden voelen. Als er echter gesprekken op gang kwamen, meldden professionals positieve resultaten, waarbij cliënten zich erkend en gesteund voelden. Weinig cliënten zeiden dat slachtofferschap op de agenda werd gezet, maar als dat gebeurde, gaven ook zij aan zich erkend en gesteund te voelen.

Hoewel professionals beweerden dat ze de interventie hadden gebruikt, bleek uit de interviews een meer flexibele en terughoudende toepassing. Dit suggereert de noodzaak van meer specifieke training, met name in het voeren van moeilijke gesprekken over ontmoediging en tegenslagen. Ervaringsdeskundigen, met hun krachtgerichte focus en persoonlijke ervaringen, waren meer vertrouwd met de aanpak.

Een striktere naleving van de interventie en de integratie ervan in behandelplannen zou het effect ervan kunnen vergroten.

Discussie (hoofdstuk 7)

Tot slot biedt **hoofdstuk 7** een reflectie op de belangrijkste bevindingen, inclusief methodologische overwegingen, praktische implicaties en aanbevelingen voor toekomstig onderzoek. Vier hoofdthema's worden besproken.

Ten eerste biedt het onderzoek inzicht in de complexe relatie tussen slachtofferschap en maatschappelijke participatie. Hoewel slachtofferschap maatschappelijke participatie in de weg kan staan, slagen sommige mensen erin om sociaal te blijven functioneren ondanks een hoge mate van slachtofferschap. Deze mensen worden echter vaak geconfronteerd met uitdagingen op andere gebieden, zoals psychosociaal functioneren en zelfvertrouwen. Het onderzoek benadrukt de noodzaak om rekening te houden met meerdere aspecten van participatie (bijv. werk, sociale betrokkenheid, buurtcohesie) en om de rol van gemeenschapsdynamiek te begrijpen. Professionals in de geestelijke gezondheidszorg moeten een evenwicht zien te vinden tussen het managen van risico's die samenhangen met participatie en het ondersteunen van herstel, in overeenstemming met het principe van 'dignity of risk'.

Ten tweede bracht de implementatie van de Victoria-interventie in de dagelijkse ggz praktijk uitdagingen met zich mee. Ondanks de inspanningen van alle betrokkenen, kwamen verschillende belangrijke problemen naar voren. Professionals waren terughoudend om gesprekken over slachtofferschap aan te gaan, vaak uit angst voor negatieve gevolgen voor cliënten. De focus van de interventie verschoof vaak van maatschappelijke participatie naar algemeen slachtofferschap, wat de toepassing ervan belemmerde. Hoewel professionals zich bewust werden van slachtofferschap en de eerste stappen toepasten, was de naleving van alle interventiestappen inconsistent. Bovendien beperkten de geringe naleving van rehabilitatiemethoden zoals de IRB en de focus op dagelijkse problemen het effect van de interventie.

Ten derde was het effect van de interventie op maatschappelijke participatie beperkt. De hypothese dat het aanpakken van slachtofferschap en discriminatie de maatschappelijke participatie zou verbeteren, werd niet bevestigd. Dit suggereert dat maatschappelijke participatie complexer en uitdagender is, zelfs voor goed getrainde teams. Bovendien is er voor het verbeteren van maatschappelijke participatie en het verminderen van stigma en discriminatie meer nodig dan een enkele interventie. Daarnaast is het mogelijk dat de focus van de interventie op het herkennen en erkennen van slachtofferschap, hoewel belangrijk, de belemmeringen van de cliënt om te participeren niet direct heeft aangepakt. Volledige implementatie vereist tijd, regelmatige herbeoordeling en vervolgacties. Daarnaast belemmert crisismanagement de rehabilitatie-inspanningen, wat wijst op de noodzaak van een meer gestructureerde en 'positieve risicobenadering' in toekomstige interventies.

Ten vierde was de invloed van de interventie op slachtofferschap, stigmatisering en discriminatie gemengd. Cliënten die Victoria-gesprekken voerden, vertoonden geen significante veranderingen in slachtofferschap. Een mogelijke reden hiervoor is dat de interventie zich niet richtte op buurtfactoren die het risico op slachtofferschap beïnvloeden. Hoewel verwachte stigmatisering en ervaren discriminatie in beide groepen in de loop van de tijd toenamen, werd er een matigend effect gezien voor discriminatie in de interventiegroep. Dit komt overeen met onderzoek dat suggereert dat discriminatie en stigmatisering verschillende concepten zijn die beïnvloed worden door verschillende sociale en psychologische factoren. Het positieve effect van de interventie op discriminatie zou verband kunnen houden met verbeterde sociale vaardigheden en veerkracht, wat de noodzaak onderstreept van verder onderzoek naar de complexe wisselwerking met maatschappelijke participatie.

Verschillende methodologische overwegingen met betrekking tot de onderzoeksopzet en het onderzoeksproces van de Victoria-interventie werden besproken. De interventie is erop gericht om professionals in de ggz een positieve risicobenadering te laten aannemen, wat een cultuuromslag vereist die langer kan duren dan de looptijd van het onderzoek toeliet. Hoewel de eerste resultaten van de RCT veelbelovend waren wat betreft het herkennen en erkennen van ervaringen met slachtofferschap, leidden ze niet tot minder slachtofferschap of meer maatschappelijke participatie. De follow-up periode van 20 maanden was mogelijk onvoldoende om significante gedragsveranderingen waar te nemen.

Het onderzoeken van de implementatie van de interventie in combinatie met de RCT leverde waardevolle inzichten op in contextuele factoren en de reacties van cliënten, maar er waren uitdagingen doordat cliënten niet rechtstreeks getraind werden, maar de professionals en door de inherente flexibiliteit, wat het meten van de effecten bemoeilijkte. Het bereiken van standaardisatie was niet haalbaar voor de Victoria interventie, omdat het afstemmen op de behoeften van de cliënt een essentieel onderdeel van de interventie was.

Het onderzoek onderstreept het belang van een goed ontwikkelde implementatiestrategie en suggereert dat een implementatieplan de resultaten had kunnen verbeteren en inzicht had kunnen bieden in de noodzakelijke veranderingen in kennis, houding en gedrag. Contextuele factoren werden na de implementatie geëvalueerd, terwijl anticiperen op voorafgaande contextuele factoren de resultaten had kunnen verbeteren.

Een volledig haalbaarheidsstudie voorafgaand aan het testen van de interventie zou nuttig zijn geweest om barrières te identificeren en de duurzaamheid te verbeteren, aangezien professionals moeite hadden om de interventie in de dagelijkse praktijk te integreren.

Over het geheel genomen zou de interventie baat hebben bij verdere verfijning voordat deze op grotere schaal getest wordt, met aanbevelingen voor meer gerichte richtlijnen voor participatiedomeinen, de aard van slachtofferschapincidenten en vervolgstappen.

Dit proefschrift belicht de uitdagingen in de aanpak van slachtofferschap onder mensen met psychische aandoeningen. Hoewel interventies het bewustzijn kunnen vergroten, hebben ze vaak een beperkt effect op het verminderen van slachtofferschap of het verbeteren van maatschappelijke participatie. Er zijn verschillende implicaties voor toekomstige interventies.

Ten eerste moeten professionals in de ggz beter worden toegerust om cliënten te ondersteunen die te maken hebben met slachtofferschap-ervaringen, inclusief de impact op hun leven. Studies uit het programma ‘Geweld tegen psychiatrische patiënten’, inclusief dit proefschrift, bieden verschillende inzichten. Ten eerste moeten toekomstige interventies worden afgestemd op specifieke subgroepen cliënten. Ten tweede, omdat bij slachtofferschap vaak bekende daders betrokken zijn, vereist dit bredere interventies dan alleen het verminderen van het aantal slachtoffers, door ook de sociale context erbij te betrekken. Ten derde blijven veel gevallen van slachtofferschap onopgemerkt en hebben ze uitgebreide ondersteuning nodig van professionals in de ggz. Zij moeten worden uitgerust met de nodige vaardigheden en kennis om cliënten te ondersteunen bij het erkennen van slachtofferschap in het verleden, het aanpakken ervan en het voorkomen van slachtofferschap in de toekomst.

Ten tweede benadrukken recente ontwikkelingen in de ggz de noodzaak om een positieve risicobenadering te integreren in herstelgerichte praktijken. Uitdagingen zijn onder andere de toegenomen vraag, beperkte middelen en een verschuiving naar probleemgerichte benaderingen. Dit kan leiden tot een conflict tussen herstelgerichte praktijken en risicomanagement. Om een positieve risicobenadering effectief te integreren in rehabilitatie, worden verschillende strategieën aanbevolen: de focus verleggen van ‘de patiënt’ naar ‘de persoon in zijn leven’, het netwerk van cliënten erbij betrekken en een gezamenlijke aanpak bevorderen die zelfbeschikking benadrukt en ruimte creëert voor veiligheid en risico.

Ten derde is een bredere kijk nodig om de impact van slachtofferschap aan te pakken. Recente ontwikkelingen, zoals de Nederlandse ‘Netwerkzorg’-aanpak, leggen de nadruk op interdisciplinaire samenwerking om copingmechanismen voor slachtofferschap te verbeteren, waarbij effectieve principes zoals peer support en resourcegroepen worden toegepast. Het integreren van resourcegroepen in FACT-teams kan empowerment bevorderen en veilige ruimten bieden voor het bespreken van slachtofferschap. Het bieden van geïntegreerde zorg kan het maatschappelijk herstel bevorderen door participatie en rehabilitatie te ondersteunen en gefragmenteerde praktijken te vermijden. Het bevorderen van veilige participatie sluit aan bij 'burgerschapsgerichte ggz', die de maatschappelijke impact van slachtofferschap erkent en de nadruk legt op het opbouwen van inclusieve gemeenschappen. Door dit bredere maatschappelijke perspectief te integreren kan de ggz niet alleen cliënten binnen hun netwerken ondersteunen, maar ook barrières voor maatschappelijke inclusie aanpakken en verminderen.

Het aanpakken van slachtofferschap-ervaringen is nuttig, maar er is verder onderzoek nodig om de effectiviteit en kwaliteit van de interventie te evalueren. Toekomstige studies moeten de ontmoediging van cliënten specifieker onderzoeken door te kijken naar verschillende levensgebieden en concrete voorbeelden van slachtofferschap-ervaringen. Meer begeleiding en training voor professionals kunnen bijdragen aan betere resultaten. Omdat slachtofferschap niet vaak voorkomt, zijn langere onderzoeksperiodes nodig om veranderingen goed te kunnen meten. Het ontwikkelen van een instrument om te beoordelen hoe goed de interventie wordt uitgevoerd, is aan te raden. Daarnaast zou onderzoek kunnen kijken naar de combinatie van de Victoria-interventie met andere bestaande interventies, zoals de resourcegroepmethode of netwerkintake. Participatief actieonderzoek kan ook een duurzame implementatie bevorderen en meer inzicht geven in de mechanismen van de interventie.

Toekomstig onderzoek moet de complexe dynamiek tussen slachtofferschap, discriminatie en maatschappelijke participatie van verschillende subgroepen onderzoeken. Het is belangrijk te begrijpen hoe slachtofferschap van invloed is op domeinen als werk en sociale steun. Door te kijken naar mensen die ondanks moeilijke omstandigheden goed blijven functioneren, kunnen we leren hoe we anderen kunnen ondersteunen. Mensen met een verstandelijke beperking hebben vaak specifieke problemen met slachtofferschap en discriminatie, en dit verdient meer aandacht in onderzoek. Kwalitatief onderzoek kan, naast kwantitatief onderzoek, dieper inzicht geven in de persoonlijke ervaringen van mensen met slachtofferschapervaringen.

Toekomstig onderzoek zou moeten kijken naar de invloed van de buurt op slachtofferschap bij mensen met EPA. Theorieën uit de criminologie en sociologie, zoals de 'social disorganization theory' en de 'social capital theory', kunnen helpen begrijpen hoe een goede buurt mensen kan beschermen tegen slachtofferschap. Onderzoek kan bijvoorbeeld kijken of buurten met hoge sociale cohesie beschermend werken en onderzoeken hoe voorlichting en buurtwerkprogramma's de acceptatie van mensen met EPA kunnen bevorderen.

Ondanks inspanningen om mensen met EPA te integreren in de samenleving, blijft hun maatschappelijke participatie achter bij die van de overige bevolking als gevolg van stigmatisering, discriminatie en slachtofferschap. Dit proefschrift onderzoekt de complexe relaties tussen slachtofferschap, discriminatie en maatschappelijke participatie bij verschillende subgroepen met EPA. Deze problemen worden vaak onvoldoende aangepakt in de reguliere zorg, zelfs na specifieke training. De Victoria-interventie, die 'dignity of risk'-principes integreert in FACT- en rehabilitatiebenaderingen, toont veelbelovend in het erkennen van slachtofferschap en het ondersteunen van herstel. Professionals in de ggz moeten echter beter worden voorbereid om een balans te vinden tussen veiligheid en empowerment en autonomie. Meer onderzoek is nodig om effectieve strategieën te identificeren, inclusief het verbeteren van de leefomgeving, om sociale inclusie te verbeteren voor mensen met ernstige psychische problemen.

A

Appendices

About the author

List of publications

Dankwoord (Acknowledgements)

About the author

Wendy Albers was born on April 12, in Venray, the Netherlands. After completing secondary school at Raayland College in Venray, she started the Bachelor's program in Business Studies at Tilburg University. During her first year, she discovered that she was more interested in humans and society than in finance and business. Therefore, she did not continue with the second year of Business Studies but decided to study Sociology instead. From 2007 to 2010, she studied Sociology at Tilburg University. After obtaining her Bachelor's degree, she began the Master's program in Social Policy and Social Interventions at Utrecht University, where she wrote her Master's thesis on the influence of attitudes toward employment on ethnic differences in societal participation. During her first Master's, she developed a deeper interest in scientific research and started the extended Master's program Sociology at Tilburg University. She interned at the Inspectorate for Social Affairs and Employment for a year, where she had the opportunity to work on several research projects. She wrote her second Master's thesis on the influence of social context on deviant behavior in neighborhoods.

In 2013, Wendy received her second Master's degree. In 2015, she started as a PhD candidate at Tranzo, the Scientific Center for Care and Wellbeing at Tilburg University. Under the supervision of Prof. Dr. Jaap van Weeghel, Prof. Dr. Inge Bongers, Dr. Diana Roeg, and Dr. Yolanda Nijssen, she coordinated and conducted research on victimization and discrimination as barriers to societal participation for individuals with severe mental illness, which resulted in her current PhD thesis. From 2019-2020, she worked as a researcher on a project focused on inclusive employment for people with psychiatric vulnerabilities.

Since September 2020, Wendy has worked as a researcher at Kwintes, an organization providing supported accommodation. She is involved in several research projects ranging from personal recovery to digital innovations, as well as improving support for and the independence of individuals in supported accommodation. Throughout her research, she has consistently focused on understanding why individuals experience difficulties in participating in society and on improving the situation for those who are unable to do so independently.

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Dankwoord (Acknowledgements)

Hij is af! Er zijn in al die jaren veel mensen in meer of mindere mate betrokken zijn geweest bij dit proefschrift en die wil ik hier graag bedanken.

Allereerst wil ik alle cliënten die hun verhaal wilden delen enorm bedanken. Zonder hen geen onderzoek. De soms heftige, maar ook veerkrachtige verhalen zullen mij nog lang bijblijven. Zij gaven kleur aan het onderzoek.

Mijn (co-)promotoren: Jaap, Inge, Diana en Yolanda. Ik had mijn geen betere begeleiding kunnen wensen. Jullie hadden allemaal een eigen rol en vulden elkaar altijd goed aan. Dank dat jullie door de jaren heen, ook na afronding van de subsidie, altijd tijd voor mij vrij maakten. Jaap, bedankt voor alle adviezen, waardevolle feedback en ruimte die ik kreeg ik om mijzelf te ontwikkelen en het project vorm te geven. Dank dat ik van jou mocht, en nog steeds mag leren. Inge, formeel ben jij geen promotor, maar jij hoort zeker in dit rijtje thuis. Jouw kennis en ervaring hebben aan alle artikelen bijgedragen, maar hebben zeker het proces artikel naar een hoger niveau getild. In de overleggen bewaakte jij ook geregeld de agenda als de discussies afdwaalden. En, dank dat je tijdens een lastig gesprek dat ik moest voeren redelijk last minute wilde aanhaken en achteraf ook even meldde dat ook jij het er warm van had. Zulke opmerkingen helpen een aio. Diana, altijd als ik weer door wilde, had jij toch nog een paar vragen of opmerkingen, en eigenlijk altijd terecht. Dank voor je kritische blik, de uitgebreide feedback op de artikelen en je enthousiasme. Bij Kwintes werken we nu ook weer samen en ook daar ben ik je erg dankbaar voor. Yolanda, ik geloof niet dat ik jou ooit chagrijnig heb gezien, zelfs niet in het begin van mijn traject toen de METC-aanvraag moeizaam ging (en dat is een understatement). Dat werkt aanstekelijk. Ik bewonder de snelheid waarmee jij in o.a. in werkbegeleidingen zag waar het pijnpunt zat en dat vervolgens scherp maar positief op tafel legde. Ook dank voor de gezellige momenten bij Dijk en Duin, en voor de goede gesprekken, ook in mindere tijden. Samen waren jullie een ijzersterk team en dankzij jullie heb ik nooit het idee gehad er alleen voor te staan. Dank.

Ook wil ik graag de deelnemende instellingen, GGzE en Dijk en Duin, bedanken voor het laten plaatsvinden en het dragen van dit onderzoek. Dank aan alle hulpverleners die aan het onderzoek hebben meegewerkt, waaronder Michael, Carin, Gijs, Paul, Manuela, Esther, Ilse, Marcel, Tineke, Leon, Gisele, Tamara, Ernst en vele anderen. Met veel interesse en humor, soms ook kritische vragen, sloten jullie toch steeds weer aan bij trainingen, werkbegeleidingen of vulden jullie vragenlijsten in. Ik heb mij altijd erg welkom op de locaties gevoeld. Speciale dank nog aan Sjaak Roza, jouw hart voor de cliënten, bevlogenheid en kennis waren onmisbaar in het proces, van ontwikkeling tot intervisie.

Hartelijk dank aan alle professionals bij R92 voor de bijdrage en financiële ondersteuning aan de IRB trainingen, de ontwikkeling en in het verdere onderzoek, Venu, Sjaak, Lies, Annemarie, Osman, Els. Bedankt voor de inzet en samenwerking.

Zoals velen weten is het werven van respondenten in een RCT vaak een uitdaging. Dat was hier niet anders. Zonder alle onderzoeksassistenten en afstudeerders was het nooit gelukt om alle hulpverleners en cliënten drie keer te spreken. Milka, Noortje, Laura, Ellis, Lora, Lisa, Merel, Freke, Stephanie, Kris, Marcel, Denise, Sacha, Mara, Mellaney, Saskia, Wendy, Hamda, Majda, Anouk, Naima, Nadja, Iris, Tim, Daphne, Nina, Sophie, Teun, Eva, Mandy, Petra en Josje: Bedankt voor jullie bijdrage aan de dataverzameling en ook zeker alle gezelligheid.

Graag wil ik ook de leden van de leescommissie, prof. dr. Kroon, prof. dr. Castelein, prof. dr. Bogaerts, dr. van Busschbach, prof. dr. Slotema en prof. dr. Delespaul bedanken voor het lezen en beoordelen van mijn proefschrift. Ik kijk ernaar uit om van gedachten te wisselen op 17 januari. Ook wil ik Mathijs Deen bedanken voor het co-auteurschap bij de effect studie, de overleggen bij Trimbos en uitgebreide antwoorden op mijn vragen over R, GEE, power berekeningen of andere methodologische vraagstukken.

Uiteraard wil ik ook alle Tranzuelen bedanken. Wat een fijne plek om te werken heb ik hier altijd gehad. Oud-kamergenoten, collega rehab onderzoekers, andere Tranzo collega's: Neis, Sarita, Juul, Wytske, Marjolein, en alle anderen die ik mogelijk nu vergeet, dank voor de gezelligheid tijdens de lunches of de uitjes, uitwisseling en steun.

Collega's van Kwintes, dank voor alle interesse en begrip tijdens de afronding van dit proefschrift. Diana en Peter, dank dat ik in de afgelopen jaren de ruimte en begrip kreeg om mijn proefschrift af te ronden.

Lieve vrienden en familie. Dank voor alle interesse en steun, geduld, humor en gezelligheid. Lynn en Desiree, wat fijn dat jullie straks achter mij staan tijdens mijn verdediging. Speciale dank nog aan Bart en Bojanna, voor de oppas woensdagen en weekenden in de afrondende fase, zodat ik ook met een andere baan en kleine Boris nog aan mijn proefschrift kon schrijven.

Guido, last but definitely not least. Degene die het meeste van dit traject heeft meegekregen, gewild of ongewild, ben jij. De afgelopen jaren, zowel tijdens mijn tijd bij Tranzo als erna, stond jij altijd naast mij. Er was best wat leed, veel verhuizingen en verbouwingen, maar ook veel liefde en mooie momenten. Het waren, en zijn, tropenjaren. Ik kan bij jou altijd terecht voor advies en ideeën, ook al werk jij in een totaal ander vakgebied. Van jouw relativeringsvermogen heb ik ook vaak gebruik gemaakt, net als jouw computer skills. Zonder jou was dit niet gelukt, echt niet. Dank voor je onvoorwaardelijke steun, je begrip, vertrouwen in mijn kunnen. Op naar de rest van ons leven, samen met B en A!